Revision: HCFA-AT-80-38 (BPP)
April 1, 1986

State MINNESOTA

SECTION 1 SINGLE STATE AGENCY ORGANIZATION

Citation
42 CFR 431.10
AT-79-29

1.1 Designation and Authority

(a) The MINNESOTA DEPARTMENT OF HUMAN SERVICES is the single State agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named in this paragraph.)

ATTACHMENT 1.1-A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which it administers or supervises administration of the program.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

Citation
Sec. 1902(a)
of the Act

1.1(b) The State agency that administered or supervised the administration of the plan approved under title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that part of this plan which relates to blind individuals.

☐ Yes. The State agency so designated is

_____

_____.

This agency has a separate plan covering that portion of the State plan under title XIX for which it is responsible.

☒ Not applicable. The entire plan under title XIX is administered or supervised by the State agency named in paragraph 1.1(a).

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

Citation Intergovernmental Cooperation Act of 1968	1.1(c)	Waivers of the single State agency requirement which are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.

☐ Yes. ATTACHMENT 1.1-B describes these waivers and the approved alternative organizational arrangements.

☐ Not applicable. Waivers are no longer in effect.

☒ Not applicable. No waivers have ever been granted.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

Citation			
42 CFR 431.10 AT-79-29	1.1(d)	☒	The agency named in paragraph 1.1(a) has responsibility for all determinations of eligibility for Medicaid under this plan.
		☐	Determinations of eligibility for Medicaid under this plan are made by the agency(ies) specified in ATTACHMENT 2.2-A. There is a written agreement between the agency named in paragraph 1.1(a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

Citation		
42 CFR 431.10 AT-79-29	1.1(e)	All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under title XI of the Act.
	(f)	All other requirements of 42 CFR 431.10 are met.

TN # _____
Supersedes
TN # 76-34

Approval Date 2-18-77 Effective Date 10-1-76

Revised: June 19, 1981

State MINNESOTA

Citation 1.2 Organization for Administration

(a) ATTACHMENT 1.2-A contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.

(b) Within the State agency, the HEALTH CARE ADMINISTRATION has been designated as the medical assistance unit. ATTACHMENT 1.2-B contains a description of the organization and functions of the medical assistance unit and an organization chart of the unit.

(c) ATTACHMENT 1.2-C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.

(d) Eligibility determinations are made by State or local staff of an agency other than the agency named in paragraph 1.1(a). ATTACHMENT 1.2-D contains a description of the staff designated to make such determinations and the functions they will perform.

__ Not applicable. Only staff of the agency named in paragraph 1.1(a) make such determinations.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

Citation
42 CFR
431.50 (b)
AT-79-29

1.3 Statewide Operation

The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50.

☐ The plan is State administered.

☒ The plan is administered by the political subdivisions of the State and is mandatory on them.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: MINNESOTA

Citation	1.4 State Medical Care Advisory Committee
42 CFR 431.12(b) AT-78-90	There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR §431.12.
42 CFR 438.104(c)	The State enrolls recipients in MCOs. The State assures that it complies with the requirements of 42 CFR §438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials.
1902(a)(73) 2107(e)(I)	**Tribal Consultation Requirements** In compliance with §1902(a)(73) of the Social Security Act, the state agency meets on a quarterly basis with tribal health directors of federally-recognized tribes, Indian Health Service (IHS)representatives, and urban Indian healthcare providers to seek advice on matters related to Medicaid and CHIP programs, including consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prepared for submission to CMS. **Ongoing consultation:** Since 1999, the state has met on a quarterly basis with tribal health directors, Indian Health Service representatives, and urban Indian healthcare providers. The quarterly meetings provide a forum for the state to solicit input from the providers on any issues of interest to them, including proposed changes to state health care programs, updates on state and federal law and regulation changes and funding opportunities. State agency policy staff attend the meetings to provide information, respond to questions, and accept comments from the providers. **Tribal participation on Medicaid Citizens' Advisory Committee:** The State Medicaid Citizens' Advisory Committee advises the state agency on issues affecting populations served by Medicaid. Representatives of the tribes who have volunteered to participate, have been appointed by the state Medicaid director to serve on the Committee. **Consultation regarding state plan amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects:** The state agency has designated a staff person in the Medicaid Director's office to act as a

liaison to the Indian health care providers regarding consultation. The liaison sends written notification to Tribal Chairs, Tribal Health Directors, and Tribal Social Services Directors, the Indian Health Service Area Office Director, and the Director of the Minneapolis Indian Health Board clinic at least ~~60~~30 days prior to the anticipated submission of all waiver requests, waiver renewals, or waiver amendments. When a 630-day notice is not possible, the longest practicable notice timeframe will be utilized.

The liaison provides written notice to Indian health care programs 30 days in advance of the anticipated submission of all proposed state plan amendments likely to have a direct effect on Indians, Indian health programs, or urban Indian organizations. Changes that are likely to have a direct effect on Indians, Indian health programs, or urban Indian organizations are those that would impact eligibility determinations, reduce payment rates, change payment methodologies, reduce covered services, or change provider qualification requirements.

When a deadline for submission of a state plan amendment is outside the control of the agency, or in severely time-limited situations, the agency expedites the process and may provide, at a minimum, 10 days advance written notice of the change.

Notices include a brief description of the proposal, its likely impact on Indian people or Indian health care providers, and a process and timeline for comment. At the request of an Indian health care provider, the liaison will send more information about any proposal.

The liaison arranges for appropriate state agency policy staff to meet with Indian health care providers to receive their input and to answer questions. This consultation may take place as part of a Quarterly Tribal Health Directors meeting or via a separate meeting, conference call, or other mechanism, as appropriate. The liaison forwards all comments received from Indian health care providers to appropriate state policy staff for their response.

When an Indian health care provider has requested changes to a proposed state plan amendment or waiver request, renewal, or amendment, the state agency liaison reports back on whether the change is included in the submission, or why it is not included. The state agency liaison informs the Indian health care providers when the State's waiver or state plan

changes are approved or disapproved by CMS, and would include CMS' rational for disapproval.

For each state plan or waiver change, the state agency liaison maintains a record of the notification process; the consultation process, including written correspondence from Indian health care providers and notes of meetings or other discussions with them, and the outcome of the process.

~~The state conducted extensive consultation with Indian health providers in the course of developing the formal consultation policy:~~

- ~~October 21, 2009: An email describing the new consultation requirements and asking for a discussion of how they should be implemented was sent to all Minnesota Indian health care providers, including 11 tribes, the Indian Health Service, and the Minneapolis Indian Health Board clinic.~~
- ~~November 17, 2009: The consultation requirements were an agenda item for the Quarterly state/Indian health meeting. It was determined there that the state would draft a proposed policy for consideration by the providers. Health directors from five tribes and the Indian Health Service were present.~~
- ~~February 2, 2010: A draft consultation policy was sent to all Indian health care providers, with request for comments and request for discussion at the next meeting.~~
- ~~February 18, 2010: At the Quarterly state/Indian health meeting, a discussion of the draft policy resulted in requests for several revisions. Representatives of seven tribes were present. Notes and materials from the meeting were subsequently sent to all Indian health care providers.~~

Revision: HCFA-PM-94-3 (MB)
APRIL 1994
State: MINNESOTA

Citation

1.5 Pediatric Immunization Program

1928 of the Act

1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.

   a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.

   b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.

   c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.

   d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.

   e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.

   f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.

   g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.

Revision: HCFA-PM-94-3 (MB)
APRIL 1994
State: MINNESOTA

Citation

1928 of the Act

2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.

3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.

4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:

_____ State Medicaid Agency

__x__ State Public Health Agency

Attachment 1.1-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of Minnesota

ATTORNEY GENERAL'S CERTIFICATION

I certify that:

The Minnesota Department of Human Services is the single State agency responsible for:

___ administering the plan.

The legal authority under which the agency administers the plan on a Statewide basis is

_____

_X_ supervising the administration of the plan by local political subdivisions and federally recognized Indian tribes.

The legal authority under which the agency supervises the administration of the plan on a State wide basis is contained in

Minnesota Statutes sections 256B.04, subd. 1 and 256.01, subd. 2(1)(g)

The agency's legal authority to make rules and regulations that are binding on the political subdivisions administering the plan is

Minnesota Statutes section 256B.04, subd. 2

Attorney General
State of Minnesota

3/29/99
Date

Alan Gilbert
Chief Deputy Attorney General
Solicitor General

TN No. 99-01
Replaces
TN No. 86-30

Approval Date: 8/16/01

Effective Date: 1/1/99

STATE: MINNESOTA
Effective: July 1, 1993
TN: 93-28
Approved: 10/12/93
Supersedes: 86-10

ATTACHMENT 1.2-C

Skilled Professional Medical Personnel
Health Care Administration

In accordance with Section 1902(a)(22)(A) of the Act, the Department employs skilled professional medical personnel (physicians, dentists, nurses, and other specialized personnel who have professional education and training in the field of medical care or appropriate medical practice) and supporting staff (secretarial, clerical, and others whose activities are directly necessary to the carrying out of the functions which are the responsibility of the skilled professional medical personnel) to administer the state's Medicaid program. Pursuant to Section 1903(a)(2)(A) of the Act, the FFP rate is 75 percent.

Minnesota's Medical Assistance program is supervised by the ~~State~~ Minnesota Department of Human Services (~~S~~DHS) and administered by the State's 87 county governments, and by American Indian Tribes with a reservation in the State who are (a) federally approved to administer a TANF program and are under contract with ~~S~~DHS to determine Medical Assistance eligibility, or (b) under contract with ~~S~~DHS to determine Medical Assistance eligibility. Local agencies are the administrative unit of county government and consist of 82 county human services agencies, and two multi-county human service agencies. The administrative unit of American Indian Tribes is the unit of tribal government designated in the contract.

Eligibility determinations prepared by employees of the local human services agencies are ultimately approved by the local agency's director or county board. Eligibility determinations prepared by the American Indian Tribes are ultimately approved by the unit of tribal government designated by the Tribe. The employees making eligibility determinations are commonly classified as financial workers. Worker job duties vary by entity and intra-organizational structure. Normally, financial workers:

- provide preapplication advice and information to potential applicants;
- process applications for assistance and make determinations to be given final approval or denial by the appropriate higher authority (however, there is no delay in action from the time of a financial worker's determination);
- manage case maintenance activities, such as handling record keeping file changes, unanticipated changes in income or property of recipients;
- perform scheduled eligibility reviews;
- process case closings; and
- refer clients to other sources of assistance.

For each American Indian Tribe under contract with DHS to determine Medicaid eligibility, the State has submitted to CMS a written agreement between the State and the Tribe describing the relationship and the respective responsibilities of the State and Tribe, including the State's oversight responsibilities in accordance with 42 CFR 431.10(d) and 431.11(d). The State assures that:

- The Tribe is processing Medicaid health care applications in accordance with the State's policies and directions and federal statute and regulatory requirements.

- Medicaid manuals and policy instructions are provided to the Tribe and that the Tribe has access to MAXIS, MMIS and to other computer systems to assure avoidance of any duplication of benefits to recipients.

- Tribal financial workers are properly trained and certified prior to performing Medicaid Eligibility tasks in the same manner as county financial workers that perform Medicaid eligibility activity. The State requires tribal financial worker attendance at policy training sessions and provide opportunity for tribal financial workers to receive policy information and assistance from the State by telephone, FAX, email, and systems.

- The requirements of section 1902(a)(8) of the Act are met regarding processing applications without delay.

- The tribe accepts and processes Medicaid applications from all members of the Tribe. The Tribe accepts applications from non tribal members and timely refer such applications to the appropriate county office for processing.

- The resolution of financial responsibility disputes between the Tribe and counties proceed under provisions of State law governing the resolution of those disputes.

- The State audits the performance of the Tribe to the same extent and in the same manner as the State audits the performance of the counties.

- The State will inform CMS within 30 days when any of the following actions related to the agreement between the State and the Tribe occurs: expiration; termination; suspension; or if any of the duties and responsibilities identified in the agreement changes.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State: MINNESOTA

SECTION 2 - COVERAGE AND ELIGIBILITY

Citation		
42 CFR 435.10 and Subpart J	2.1	Application, Determination of Eligibility and Furnishing Medicaid
	(a)	The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

Revision: HCFA-PM-91-4 (BPD)
August 1991

State MINNESOTA

Citation		
42 CFR 435.914 1902(a)(34) of the Act	2.1(b)(1)	Except as provided in items 2.1(b)(2) and below, individuals are entitled to Medicaid services under the plan during the three month preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in ATTACHMENT 2.6-A.
1902(e)(8) and 1902(a) of the Act	(2)	For individuals who are eligible for Medicaid cost sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month in which the individual is first determined to be a qualified Medicare beneficiary. ATTACHMENT 2.6-A specifies the requirements for determination of eligibility for this group.
1902(a)(47) and 1920 of the Act	___ (3)	Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. ATTACHMENT 2.-6-A specifies the requirements for determination of eligibility for this group.
~~42 CFR 434.20~~ 42 CFR 438.50(b)(3)	2.1(c)	The Medicaid agency elects to enter into a comprehensive risk contract with ~~an HMO~~ a MCO that is _____ ~~Qualified under Title XIII of the Public Health Service Act or is provisionally qualified as an HMO pursuant to section 1903(m)(3) of the Social Security Act.~~ _x_ ~~Not Federally qualified, but meets the requirements of 42 CFR §434.20(c) and is~~ defined in 42 CFR 438.2 and in ATTACHMENT 2.1-A. _____ Not applicable.

State/Territory: MINNESOTA

Citation

1902(a)(55) of the Act	2.1(d)	The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in § 1902(a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), and (a)(10)(A)(ii)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the AFDC form except as permitted by HCFA instructions.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements
Eligibility Process

S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☐ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☒ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☐ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

☐ Yes ◉ No

Medicaid Eligibility

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

- ■ Once every 12 months
- ■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency
- ■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

- ☒ Once every 12 months
- ☒ Once every 6 months
- ☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION

☒Paper Application ☐Online Application

TRANSMITTAL NUMBER:	**STATE:**
MN-130027-MM2	Minnesota

Through June 30, 2014 the state is using an interim paper alternative single streamlined application. After June 30, 2014, the state will use a revised paper alternative single streamlined application. The revised application will address the issues outlined in the CMS companion letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION

☐ Paper Application ☒ Online Application

TRANSMITTAL NUMBER:	**STATE:**
MN-130027-MM2	Minnesota

Through June 30,2014 the state is using an interim online alternative single streamlined application. As of July 1, 2014 the state will use a revised online alternative single streamlined application. The revised application will address the issues outlined in the CMS companion letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.

State: MINNESOTA

Citation
42 CFR
435.10

2.2 Coverage and Conditions of Eligibility

Medicaid is available to the groups specified in ATTACHMENT 2.2-A.

/ / Mandatory categorically needy and other required special groups only.

/ / Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.

/ / Mandatory categorically needy, other required special groups, and specified optional groups.

/X/ Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: 13-0027 MM5	**STATE:** Minnesota
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: S88 Non-Financial Eligibility- State Residency	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT* *(If Applicable)*:** Attachment 2.6-A: Page 3, TN 98-06 Section 2.3, TN 87-27 *S88 supersedes the above Minnesota Medicaid State Plan pages, without regard to the limitation to MAGI populations required by the MMDL submission.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State: Minnesota

Citation
435.10 and
435.403, and
1902(b) of the Act,
P. L. 99-272
(Section 9529)
and P. L. 99-509
(Section 9405)

2.3 Residence

~~Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.~~

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State: MINNESOTA

Citation
42 CFR 435.530(b)
42 CFR 435.531
AT-78-90
AT-79-29

2.4 Blindness

All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.

2

Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
AUGUST 1991

State: MINNESOTA

Citation	2.5	Disability
42 CFR 435.121, 435.540(b) 435.541		All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.13.b. of ATTACHMENT 2.2-A of this plan.

Revision: HCFA-PM-92-1 (MB)
FEBRUARY 1992

STATE: MINNESOTA

Citation(s)

42 CFR 435.10 and Subparts G & H; 1902 (a)(10)(A)(i)(III), (IV), (V), (VI), and (VII), 1902(a)(10)(A)(ii)(IX), 1902(a)(10)(A)(ii)(X), 1902(a)(10)(C), 1902(f), 1902(l) and (m), 1905(p) and (s), 1902 (r)(2), and 1920

2.6 Financial Eligibility

(a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.

Revision: HCFA-PM-86-20 (BERC) OMB-No. 0938-0193
SEPTEMBER 1986

State/Territory: MINNESOTA

Citation	2.7	Medicaid Furnished Out of State
431.52 and 1902(b) of the Act, P.L. 99-272 (Section 9529)		Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.

~~"Health Maintenance Organization" (HMO)~~ "Managed Care Organization" (MCO) means an entity ~~which~~ that has, or is seeking to qualify for, a comprehensive risk contract, and that is:

1. ~~provides, either directly or through arrangements with providers or other persons or entities, comprehensive health services for a fixed sum without regard to the frequency or extent of services furnished to a particular enrollee~~ a Federally qualified health maintenance organization (as defined in 42 CFR §438.2) that meets the advance directives requirements of 42 CFR §489.100-.104; or

2. ~~is organized primarily for the purpose of providing health care services;~~

3. ~~makes the services it provides to its Medicaid enrollees as accessible to them as those services are to non-Medicaid enrollees within the HMO's service area, in terms of timeliness, amount, duration and scope; and~~

4. ~~makes provision against the risk of insolvency to the satisfaction of the State and assures that Medicaid enrollees will not be liable for the HMO's debts in the event of insolvency~~ any public or private entity that meets the advance directives requirements of 42 CFR §489.100-.104 and is determined to also meet the following conditions:

   A. Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration and scope) as those services are to other Medicaid recipients within the area served by the entity; and

   B. Meets the solvency standards of 42 CFR §438.116.

This definition includes, but is not limited to:

1. a non-profit corporation ~~or any statutory or home rule charter city or county~~ that has been issued a certificate of authority by the Department of Health pursuant to Minnesota Statutes, chapter 62D; ~~and~~

2. a community integrated service network ~~(CISN)~~ licensed by the Department of Health pursuant to Minnesota Statutes, chapter 62N; and

3. a county-based purchaser meeting county-based purchasing requirements in state law.

SUPERSEDING & OBSOLETE PAGES OF STATE PLAN MATERIAL		
TRANSMITTAL NUMBER: MN-130027-MM1	**STATE:** Minnesota	

Pages or sections of pages being superseded by S25, S28, S30, S51, S52, S53, S54, and S14 and related pages or sections of pages being deleted as obsolete by CMS

State Plan Section	Complete Pages Superseded	Partial Pages Superseded	Preprint deemed obsolete by CMS
Attachment 2.2-A	Page 1 Page 3 Page 3a Page 4 Page 4a Page 12, TN 91-26 Page 13,TN 09-001 Page 14 Page 21 Page 23b	Page 2, under item A.2 remove b and c Page 2a, under item A, remove number 3 Page 5, under item A, remove number 10 Page 9c, under item B.1, remove "Caretaker relatives" and "Pregnant women." Page 13a, except number 7(b)6 is retained.	Page 14a Page 23 Page 20, B.14 Page 25, C.4
Attachment 2.6-A	Page 1, A.2.a(i) and (iii) Page 11a Page 19 Page 19a Page 19b Page 21	Page 1, A.2.a(i) and (iii) Page 6, related to AFDC recipients, pregnant women, infants, and children, except to the extent relevant to the AFDC-related medically needy group.	Page 3b Page 25, 11.a(3)

		Page 7, 1.a(1) and (2) Page 12, 5.e(2) Page 18, 5.e	
Supplement 1 to Attachment 2.6-A	Pages 1-4 of 7		
Supplement 2 to Attachment 2.6-A	Pages 1-5 of 7		
Supplement 8a to Attachment 2.6-A	Page 3	Page 2, delete 1st disregard for pregnant women & infants and 3rd disregard for AFDC-related groups Page 5, delete all disregards except those for medically needy Page 6, delete all disregards for AFDC-related categorically needy groups	
Supplement 8b to Attachment 2.6-A		Pages 1, 2a & 5, delete all disregards for AFDC-related categorically needy groups	
Supplement 13 to Attachment 2.6-A	Pages 1-3		
Supplement 14 to Attachment 2.6-A			Page 1

State: Minnesota

Citation	Condition or Requirement

A. General Conditions of Eligibility

Each individual covered under the plan:

42 CFR Part 435, in Subpart G — 1. Is financially eligible (using the methods and standards described Parts B and C of this Attachment) to receive services.

42 CFR Part 435 Subpart F — 2. Meets the applicable non-financial eligibility conditions.

a. For the Categorically needy:

~~(i) Except as specified under items A.2.a.(ii) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.~~

(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.

1902(l) of the Act — ~~(iii) For financially eligible pregnant women, infants or children covered under sections 1902(a)(10)(A)(i)(IV), (VI), (VII), and 1902(a))10)(A)(ii)(IX) of the Act, meets the non-financial criteria of section 1902(l) of the Act.~~

1902(m) of the Act — (iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: 13-0027 MM6	**STATE:** Minessota
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT* *(If Applicable)*:**
S89 Non-Financial Eligibility- Citizenship and Non-Citizen Eligibility	Attachment 2.6-A: Page 2, Item 3, Subparagraphs (a), (b), (c), and (d), TN 10-009 Attachment 2.6-A: Page 2a, TN 10-009 Attachment 2.6-A, Page 2b, TN 10-009 *S89 supersedes the above Minnesota Medicaid State Plan pages, without regard to the limitation to MAGI populations required by the MMDL submission.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

1902(a)(46)(B)
8 U.S.C. 1611, 1612, 1613, and 1641
1903(v)(2),(3) and (4)
42 CFR 435.4
42 CFR 435.406
42 CFR 435.956

Citizenship and Non-Citizen Eligibility

☑ The state provides Medicaid to citizens and nationals of the United States and certain non-citizens consistent with requirements of 42 CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.

■ The state provides Medicaid eligibility to otherwise eligible individuals:

■ Who are citizens or nationals of the United States; and

■ Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); and

■ Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, and 956.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

◉ Yes ○ No

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.

◉ Yes ○ No

The date benefits are furnished is:

○ The date of application containing the declaration of citizenship or immigration status.

○ The date the reasonable opportunity notice is sent.

◉ Other date, as described: The start date of eligibility under the State Plan.

Medicaid Eligibility

The state provides Medicaid coverage to all Qualified Non-Citizens whose eligibility is not prohibited by section 403 of PRWORA (8 U.S.C. §1613).

◉ Yes ○ No

The state elects the option to provide Medicaid coverage to otherwise eligible individuals under 21 and pregnant women, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

◉ Yes ○ No

☒ Pregnant women

☒ Individuals under age 21:

◉ Individuals under age 21

○ Individuals under age 20

○ Individuals under age 19

▣ An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan.

▣ An individual is considered to be lawfully present in the United States if he or she:

1. Is a qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

2. Is a non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

3. Is a non-citizen who has been paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

4. Is a non-citizen who belongs to one of the following classes:

▣ Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;

▣ Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

▣ Granted employment authorization under 8 CFR 274a.12(c);

▣ Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

▣ Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

▣ Granted Deferred Action status;

▣ Granted an administrative stay of removal under 8 CFR 241;

▣ Beneficiary of approved visa petition who has a pending application for adjustment of status;

5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231, or under the Convention Against Torture who -

▣ Has been granted employment authorization; or

▣ Is under the age of 14 and has had an application pending for at least 180 days;

6. Has been granted withholding of removal under the Convention Against Torture;

7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);

8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or

9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b));

10. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

☐ Other

☑ The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the SSA and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present an SSN:

■ Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613;

■ Non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 435.406(b).

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: Minnesota

Citation	Condition or Requirement

b. For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.

c. For financially eligible qualified Medicare Beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, meets the non-financial criteria of section 1905(p) of the Act.

d. For financially eligible qualified disabled and working individuals covered under section 1902(a)(10(E)(ii) of the Act, meets the nonfinancial criteria of section 1905(s).

e. For financially eligible specified low income Medicare beneficiaries covered under section 1902(A)(10(e)(iii) and 1905(P) (3)(A)(ii).

~~3. Is residing in the United States and~~

~~a. Is a citizen;~~

~~b. Is a qualified alien, as defined in section 431(b) of P.L. 104-193 as amended, whose coverage is mandatory under section 402 and 403 of P.L. 104-193 as amended, including those who entered the United States prior to August 22, 1996 and those who entered on or after August 22, 1996.~~

~~x~~ ~~Is a qualified alien, as defined in section 431(b) of P.L. 104-193 as amended, whose coverage is optional under sections 420 and 403 of P.L. 104-193 as amended, including those who entered the United States prior to August 22, 1996 and those who entered on or after August 22, 1996.~~

~~c. Is an alien who is not a qualified alien, as defined in section 431(b) of P.L. 104-193 as amended, or who is a qualified alien but is not eligible under the provisions of (b) above. (Coverage is restricted to certain emergency services.)~~

State: Minnesota

Citation	Condition or Requirement
1903(v)(4) of the Act	d. ~~The state elects the option in section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to provide full Medicaid coverage to otherwise eligible noncitizen pregnant women and children who are lawfully residing in the United States~~: ~~A pregnant woman or child shall be considered lawfully present if he or she is:~~ ~~(1) A qualified alien as defined in section 431 of PRWORA (8 U.S. C. §1641);~~ ~~(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;~~ ~~(3) An alien who has been paroled into the united States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;~~ ~~(4) An alien who belongs to one of the following classes:~~ ~~(i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);~~ ~~(ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;~~ ~~(iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);~~ ~~(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;~~ ~~(v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;~~ ~~(vi) Aliens currently in deferred action status; or~~ ~~(vii) Aliens who are the spouse or child of a U.S. citizen whose visa petition has been approved and~~

State: Minnesota

Citation	Condition or Requirement

who have a pending application for adjustment of status.

(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. §1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. §1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;

(6) An alien who has been granted withholding of removal under the Convention Against Torture;

(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));

(8) An alien who is lawfully present in the commonwealth of the Northern Mariana Islands under 48 U.S. C. §1806(e);

(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

__x__ Elected for pregnant women
__x__ Elected for children under 21

d. __X__ The state assures that for individuals enrolled under the CHIP RA section 214 option the state verifies lawful residence at the time of the individual's initial eligibility determination and at an eligibility redetermination that an individual continues to lawfully reside the United States. At redetermination, the state determines if documentation from the initial application is satisfactory for determining that the individual continues to lawfully reside in the U.S. or if the individual must provide additional documentation to establish a lawfully residing status.

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: 13-0027 MM5	**STATE:** Minnesota
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: S88 Non-Financial Eligibility- State Residency	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT* *(If Applicable)*:** Attachment 2.6-A: Page 3, TN 98-06 Section 2.3, TN 87-27 *S88 supersedes the above Minnesota Medicaid State Plan pages, without regard to the limitation to MAGI populations required by the MMDL submission.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Non-Financial Eligibility
State Residency

42 CFR 435.403

State Residency

☑ The state provides Medicaid to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

Individuals are considered to be residents of the state under the following conditions:

■ Non-institutionalized individuals age 21 and over, or under age 21, capable of indicating intent and who are emancipated or married, if the individual is living in the state and:

- ■ Intends to reside in the state, including without a fixed address, or
- ■ Entered the state with a job commitment or seeking employment, whether or not currently employed.

■ Individuals age 21 and over, not living in an institution, who are not capable of indicating intent, are residents of the state in which they live.

■ Non-institutionalized individuals under 21 not described above and non IV-E beneficiary children:

- ■ Residing in the state, with or without a fixed address, or
- ■ The state of residency of the parent or caretaker, in accordance with 42 CFR 435.403(h)(1), with whom the individual resides.

■ Individuals living in institutions, as defined in 42 CFR 435.1010, including foster care homes, who became incapable of indicating intent before age 21 and individuals under age 21 who are not emancipated or married:

- ■ Regardless of which state the individual resides, if the parent or guardian applying for Medicaid on the individual's behalf resides in the state, or
- ■ Regardless of which state the individual resides, if the parent or guardian resides in the state at the time of the individual's placement, or
- ■ If the individual applying for Medicaid on the individual's behalf resides in the state and the parental rights of the institutionalized individual's parent(s) were terminated and no guardian has been appointed and the individual is institutionalized in the state.

■ Individuals living in institutions who became incapable of indicating intent at or after age 21, if physically present in the state, unless another state made the placement.

■ Individuals who have been placed in an out-of-state institution, including foster care homes, by an agency of the state.

■ Any other institutionalized individual age 21 or over when living in the state with the intent to reside there, and not placed in the institution by another state.

■ IV-E eligible children living in the state, or

State: MINNESOTA

Citation	Condition or Requirement
42 CFR 435.403 1902(b) of the Act	~~4. Is a resident of the State, regardless of whether or not the individual maintains the residence permanently or maintains it at a fixed address.~~ ~~X State has interstate residency agreement with the following States:~~ ~~North Dakota (effective August 1, 1993)~~ ~~____ State has open agreements~~ ~~____ Not applicable; no residency requirement.~~

Citation	Condition or Requirement
435.1008	5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, intermediate care facilities, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 CFR 435.1008 1905(a) of the Act	b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. ☐ Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
433.145 435.604 1912 of the Act	6. Is required, as a condition of eligibility, to assign rights to medical support and to payments for medical care from any third party, to cooperate in obtaining such support and payments, and to cooperate in identifying and providing information to assist in pursuing any liable third party. The assignment of rights obtained from an applicant or recipient is effective only for services that are reimbursed by Medicaid. The requirements of 42 CFR 433.146 through 433.148 are met. ☐ Assignment of rights is automatic because of State law.
42 CFR 435.910	7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number).

State: MINNESOTA

Citation	Condition or Requirement
1902(c)(2)	~~8. Is not required to apply for AFDC benefits under title IV-A as a condition of applying for, or receiving, Medicaid if the individual is a pregnant woman, infant, or child that the State elects to cover under sections 1902(a)(10(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.~~
1902(e)(10)(A) and (B) of the Act	~~9. Is not required, as an individual child or pregnant woman, to~~ meet ~~requirements under section 402(a)(43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a State's AFDC plan, the agency determines if they are otherwise eligible under the State's Medicaid plan.)~~

Citation	Condition or Requirement
	An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902(l)(1)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate. An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate. / / Assignment of rights is automatic because of State law.
42 CFR 435.910	7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number), EXCEPT FOR ALIENS SEEKING MEDICAL ASSISTANCE FOR THE TREATMENT OF AN EMERGENCY MEDICAL CONDITION UNDER 1903(v)(2) OF THE SOCIAL SECURITY ACT.

Citation	Condition or Requirement
1906 of the Act	10. Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).

State: MINNESOTA

Citation	Condition or Requirement
	B. Posteligibility Treatment of Institutionalized Individuals' Incomes
	1. The following items are not considered in the posteligibility process:
1902(o) of the Act	a. SSI and SSP benefits paid under §1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF.
Bondi v Sullivan (SSI)	b. Austrian Reparation Payments (pension (reparation) payments made under §500 - 506 of the Austrian General Social Insurance Act). Applies only if State follows SSI program rules with respect to the payments.
1902(r)(1) of the Act	c. German Reparations Payments (reparation payments made by the Federal Republic of Germany).
105/206 of P. L. 100-383	d. Japanese and Aleutian Restitution Payments.
1. (a) of P.L. 103-286	e. Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II).
10405 of P.L. 101-239	f. Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.)
6(h)(2) of P.L. 101-426	g. Radiation Exposure Compensation.
12005 of P. L. 103-66	h. VA pensions limited to $90 per month under 38 U.S.C. 5503.
	j. Blood Products Settlement Payments described in Supplement 15 To Attachment 2.6-A.
606 of P. L. 105-78	k. Payments by the Secretary of Defense to persons captured and interned by North Vietnam pursuant to section 657 of P. L. 104-201.
201 of P. L. 105-369	l. Payment under the Ricky Ray Hemophilia Relief Fund Act of 1998.

Citation	Condition or Requirement
1924 of the Act 435.725 435.733 435.832	2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care: Personal Needs Allowance (PNA) of not less than $30 For Individuals and $60 For Couples For All Institutionalized Persons. a. Aged, blind, disabled: Individuals $ 64 * Couples $ 64 * per person For the following persons with greater need: Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. b. AFDC related: Children $ 64 * Adults $ 64 * For the following persons with greater need: Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. c. Individual under age 21 covered in the plan as specified in Item B. 7. of Attachment 2.2 -A. $ 64 *

* This amount is increased annually by the same percentage applied to SSI/RSDI benefits for a cost of living adjustment.

Citation	Condition or Requirement

For the following persons with greater need:

Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and where appropriate, identifies the organizational unit which determines that a criterion is met.

1924 of the Act

3. In addition to the amounts under item 2, the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse:

a. The monthly income allowance for the community spouse, using the formula in §1924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in §1924 (d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.

__X__ The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level.

____ The poverty level component is calculated using a percentage greater than the applicable percentage, equal to _____%, of the official poverty level (still subject to maximum maintenance needs standard).

_____ The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C).

Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court-ordered support.

Citation	Condition or Requirement

In determining any excess shelter allowance, utility expenses are calculated using:

__X__ The standard utility allowance under §5 of the Food Stamp Act of 1977; or

____ the actual unreimbursable amount of the community Spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.

b. The monthly income allowance for other dependent family members living with the community spouse is:

__X__ one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924(d)(3)(B) exceeds the dependent family member's monthly income.

_____ a greater amounted calculated as follows:

The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924 (d)(1): (Not applicable)

c. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party:

(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.

(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6-A.)

Citation		Condition or Requirement
	X	Amount for maintenance of home is: The poverty-level income standard for a household of one under §1902(a)(10)(A)(ii)(X) ~~medically needy income standard~~ for elderly and disabled ~~an aged, blind or disabled person~~, less the personal needs allowance.
	____	Amount for maintenance of home is the actual maintenance costs not to exceed $_____.
	____	Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individuals' home and the community spouse's home are different.
	X	Amount for maintenance of home is not deductible when countable income is determined under §1924 (d)(1) of the Act.

Citation	Condition or Requirement

42 CFR 435.711
435.721
435.831

C. Financial Eligibility

For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified in Supplements 4, 5, 7, 8, 8a, and 8b to ATTACHMENT 2.6-A.

For individuals who are not AFDC or SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply.

Supplement 1 to Attachment 2.6-A specifies the income levels for mandatory and optional categorically needy groups and medically needy groups of individuals, including ~~individuals with incomes related to the Federal income poverty level--pregnant women and infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), and 1902(a)(10)(A)(ii)(IX) of the Act and~~ aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, and individuals covered under section 1902(a)(10)(A)(ii)(V) --and for mandatory groups of qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(I) of the Act.

Supplement 2 to Attachment 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.

Supplement 3 to Attachment 2.6-A specifies reasonable limits on amounts for necessary medical and remedial care expenses not covered under Medicaid.

State: Minnesota

Citation	Condition or Requirement
X	Supplement 4 to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
X	Supplement 5 to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
X	Supplement 6 to ATTACHMENT 2.6-A specifies the standards for optional state supplementary payments.
X	Supplement 7 to ATTACHMENT 2.6-A specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.
X	Supplement 8a to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.
X	Supplement 8b to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.
X	Supplement 8c (draft template) to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by ~~States~~ this State that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.
X	Supplement 9 to ATTACHMENT 2.6-A specifies the asset transfers which affect the eligibility of institutionalized individuals.
X	Supplement 10 to ATTACHMENT 2.6-A specifies the criteria used to exclude the funds in a Medicaid Qualifying Trust because of undue hardship for categorically and medically needy individuals, as permitted under section 1902(k)(4) of the Act.
X	Supplement 12 to ATTACHMENT 2.6-A describes variations from the basic personal needs allowance for institutionalized individuals with greater need in the post-eligibility treatment of income.
X	Supplement 13 to ATTACHMENT 2.6-A specifies the eligibility for low-income families under section 1931 of the Act.
X	Supplement 15 to ATTACHMENT 2.6-A specifies that Blood Product Settlement Payments will be excluded from income and resource consideration for all categorically and medically needy groups covered by the State under the Act.
X	Supplement 17 to ATTACHMENT 2.6-A specifies the disqualification for long-term care assistance for individuals with substantial home equity.

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: MN-13-0027-M3	**STATE:** Minnesota
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: S10 - MAGI Income Methodology	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:** Notwithstanding any other provisions of the Minnesota Medicaid State Plan, the financial eligibility methodologies described in State Plan Amendment MN-13-0027-M3 and set forth in 42 CFR § 435.603, will apply to all MAGI-based eligibility groups covered under Minnesota's Medicaid State Plan. These eligibility methodologies do not apply to those individuals described at 42 CFR § 435.603(j). State Plan Amendment MN-13-0027-M3 supersedes the current financial eligibility provisions of the Medicaid State Plan only with respect to the MAGI-based eligibility groups, effective January 1, 2014.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

MAGI-Based Income Methodologies **SI0**

1902(e)(14)
42 CFR 435.603

☑ The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.

In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014, or the next regularly-scheduled renewal of eligibility, whichever is later, if application of such methods results in a determination of ineligibility prior to such date.

In determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- ○ The pregnant woman is counted just as herself.
- ○ The pregnant woman is counted as herself, plus one.
- ◉ The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- ◉ Current monthly household income and family size
- ○ Projected annual household income and family size for the remaining months of the current calendar year

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- ☒ Include a prorated portion of a reasonably predictable increase in future income and/or family size.
- ☒ Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

In determining eligibility for Medicaid, an amount equivalent to 5 percentage points of the FPL for the applicable family size will be deducted from household income in accordance with 42 CFR 435.603(d).

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

○ Yes ◉ No

Medicaid Eligibility

☒ The age used for children with respect to 42 CFR 435.603(f)(3)(iv) is:

◉ Age 19

○ Age 19, or in the case of full-time students, age 21

PRA Disclosure Statement

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Minnesota

ELIGIBILTY CONDITIONS AND REQUIREMENTS

Citation	Condition or Requirement
1902(r)(2) of the Act	1. Methods of Determining Income
	a. ~~AFDC-related individuals (except for poverty level related pregnant women, infants, and children).~~
	~~(1) In determining countable income for AFDC-related individuals, the following methods are used:~~
	~~___ (a) The methods under the State's approved AFDC plan only; or~~
	~~X (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8a to Attachment 2.6-A.~~
	~~(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.~~
1902(e)(6) of the Act	(3) Agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day fall.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.721 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act	b. Aged individuals. In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(1) of the Act, the following methods are used: ___ The methods of the SSI program only. X The methods of the SSI program and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

Citation	Condition or Requirement

X For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

/ For institutional couples, the methods specified under section 1611(e)(5) of the Act.

□ For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.

X For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--

___ SSI methods only.

___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.

X Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

Citation	Condition or Requirement
42 CFR 435.721 and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	c. Blind individuals. In determining countable income for blind individuals, the following methods are used: ___ The methods of the SSI program only. X SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. X For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A, and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ___ For institutional couples, the methods specified under section 1611(e)(5) of the Act. ___ For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A. X For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements-- ___ SSI methods only. X SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. ___ Methods more restrictive and/ or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

Citation	Condition or Requirement
	In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
42 CFR 435.721, and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	d. Disabled individuals. In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act the following methods are used: ___ The methods of the SSI program. X SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ___ For institutional couples: the methods specified under section 1611(e)(5) of the Act. ___ For optional State supplement recipients under §435.230: income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A. X For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

Citation	Condition or Requirement

X For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--

___ SSI methods only.

___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.

X Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m)(1) of the Act. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

State: MINNESOTA

Citation	Condition or Requirement
1902(l)(3)E), and 1902(r)(2) of the Act	e. ~~Poverty level pregnant women, infants, and children. For pregnant women, infants, or children covered under the provisions sections 1902(a)(10)(A)(i)(IV), (VI), and (VII), and 1902(a)(10)(A)(ii)(IX) of the Act~~ -- ~~(1) The following methods are used in determining countable income:~~ ____ ~~The methods of the State's approved AFDC plan.~~ ____ ~~The methods of the approved title IV-E plan.~~ ~~X~~ ~~The methods of the approved AFDC State plan and/or any more liberal methods described in Supplement 8a to Attachment 2.6-A.~~ ____ ~~The methods of the approved title IV-E plan and/or any more liberal methods described in Supplement 8a to Attachment 2.6-A~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Minnesota

ELIGIBILTY CONDITIONS AND REQUIREMENTS

Citation		Condition or Requirement
	(~~2~~)	~~In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.~~
1902(e)(6) of the Act	(3)	The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.
1905(p)(1), 1902(m)(4). and 1902(r)(2) of the Act	f.	Qualified Medicare beneficiaries. In determining countable Income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i)of the Act, the following methods are used: _____ The methods of the SSI program only. _____ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to Attachment 2.6-A. ____ For institutional couples, the methods specified under section 1611(e)(5) of the Act.

Citation		Condition or Requirement
		If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level. For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period. For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.
1905(s) of the Act	g.	(1) Qualified disabled and working individuals. In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.
1905(p) of the Act		(2) Specified low-income Medicare beneficiaries. In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.

* U.S. G.P.O.:1993-342-239:80032

Citation	Condition or Requirement
1902(u) of the Act	(h) COBRA Continuation Beneficiaries In determining countable income for COBRA continuation beneficiaries, the following disregards are applied: _____ The disregards of the SSI program; _____ The agency uses methodologies for treatment of income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A. NOTE: For COBRA continuation beneficiaries specified at 1902(u)(4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b)(4)(B)(ii).

State/Territory: Minnesota

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XIII) of the Act	(i) Working Individuals with Disabilities - BBA In determining countable income and resources for working individuals with disabilities under the BBA, the following methodologies are applied: ____ The methodologies of the SSI program. ____ The agency uses methodologies for treatment of income and resources more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 (income) and/or Supplement 5 (resources) to Attachment 2.6-A. _X__ The agency uses more liberal income and/or resource methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A. __X__ The agency requires individuals to pay premiums or other cost-sharing charges. The premiums or other cost-sharing charges, and how they are applied, are described on page 12m.

State/Territory: Minnesota

Citation		Condition or Requirement
1902(a)(10)(A)(ii)(XV) of the Act	(ii)	Working Individuals with Disabilities - Basic Coverage Group - TWWIIA

In determining financial eligibility for working individuals with disabilities under this provision, the following standards and methodologies are applied:

____ The agency does not apply any income or resource standard.

NOTE: If the above option is chosen, no further eligibility-related options should be elected.

~~X~~ The agency applies the following income and/or resource standard(s):

~~No income standard is applied.~~

~~The resource standard is $20,000 in nonexcluded resources.~~

State/Territory: Minnesota

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XV) of the Act (cont.)	Income Methodologies In determining whether an individual meets the income standard described above, the agency uses the following methodologies. ____ The income methodologies of the SSI program. ____ The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A. __X__ The agency uses more liberal income methodologies than the SSI program. More liberal income methodologies are described in Supplement 8a to Attachment 2.6-A.

State/Territory: Minnesota

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XV) of the Act (cont.)	Resource Methodologies In determining whether the individual meets the resource standard described above, the agency uses the following methodologies. Unless one of the following items is checked the agency, under the authority of section 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in Supplement 8b to Attachment 2.6-A. ____ The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans. ~~X~~ The agency disregards funds in retirement accounts in a manner other than those described above. The agency's disregards are specified in Supplement 8b to Attachment 2.6-A.

State/Territory: Minnesota

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act (cont.)	____ The agency does not disregard funds in retirement accounts. ~~X~~ The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A. ____ The agency uses the resource methodologies of the SSI program. ____ The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6-A.

State/Territory: Minnesota

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XIII), (XVI), and 1916(g) of the Act	Payment of Premiums or Other Cost Sharing Charges For individuals eligible under the BBA eligibility group described in No. 23 on page 23d of Attachment 2.2-A: X The agency requires payment of premiums or other cost-sharing charges on a sliding scale based on income. The premiums or other cost-sharing charges, and how they are applied, are described below: Payment of a minimum premium of $35 per month or a premium on a sliding scale, whichever is greater, applies to all individuals. The sliding scale premium amount is based on a person's income, the applicable family size and a sliding fee scale that begins at one percent of income at 100 percent of the Federal poverty guidelines and increases to 7.5 percent up to income of 300 percent of the Federal poverty guidelines, and remains at 7.5 percent for income above 300 percent of the Federal poverty guidelines. Annual adjustments based upon changes in the federal poverty guidelines are effective July 1 of each year. All individuals pay a cost-sharing charge of one-half of one percent of income.

State/Territory: Minnesota

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XV), and 1916(g) of the Act (cont.)	For individuals eligible under the Basic Coverage Group described in No. 24 on page 23d of Attachment 2.2-A: NOTE: Regardless of the option selected below, the agency MUST require that individuals whose annual adjusted gross income, as defined under IRS statute, exceeds $75,000 pay 100 percent of premiums. ~~X~~ The agency requires individuals to pay premiums or other cost-sharing charges on a sliding scale based on income. For individuals with net annual income below 450 percent of the Federal poverty level for a family of the size involved, the amount of premiums cannot exceed 7.5 percent of the individual's income. The premiums or other cost-sharing charges, and how they are applied, are described on page 12o.

State/Territory: __Minnesota

Citation	Condition or Requirement
Sections 1902(a)(10)(A)(ii)(XV) and 1916(g) of the Act (cont.)	Premiums and Other Cost-Sharing Charges For the Basic Coverage Group the agency's premium or other cost-sharing charges, and how they are applied, are described below. ~~Payment of a minimum premium of $35 per month or a premium on a sliding scale, whichever is greater, applies to all individuals. The sliding scale premium amount is based on a person=s gross earned and unearned income, the applicable family size and a sliding fee scale that begins at one percent of income at 100 percent of the Federal poverty guidelines and increases to 7.5 percent up to income of 300 percent of the Federal poverty guidelines, and remains at 7.5 percent for income above 300 percent of the Federal poverty guidelines.~~ ~~Annual adjustments based upon changes in the federal poverty guidelines are effective July 1 of each year.~~ ~~All individuals pay a cost-sharing charge of one-half of one percent of gross unearned income.~~

State: MINNESOTA

Citation		Condition or Requirement
1917(d) and 1902(k) of the Act	2.	~~Medicaid-Qualifying~~-Trusts Medicaid Qualifying Trusts. In the case of Medicaid qualifying trust established before August 11, 1993 and described in section 1902(k) of the Act, the amount from the trust or similar legal device that is deemed available to the individual who established the trust (or whose spouse established the trust or similar legal device) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded. X The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. Supplement 10 of ATTACHMENT 2.6-A specifies what constitututes undue hardship. Other Trusts. In the case of trusts described in § 13611 of P.L. 103-66 established on or after August 11, 1983, the State complies with § 13611 of P.L. 103-66. All other trusts are subject to the policies of the SSI Program.
1902(a)(10) of the Act	3.	Medically needy income levels (MNILs) are based on family size. Supplement 1 to ATTACHMENT 2.6-A specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, Supplement 1 so indicates.

Citation	Condition or Requirement
42 CFR 435.732, 435.831	4. Handling of Excess Income - Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States Only

a. Medically Needy

(1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of either 1 or 6 month(s) (not to exceed 6 months) to determine the amount of excess countable income applicable to the cost of medical care and services. THE RECIPIENT CHOOSES WHICH BUDGET PERIOD TO APPLY IN DETERMINING ELIGIBILITY.

(2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:

(a) Health insurance premiums, deductibles and coinsurance charges.

(b) Expenses for necessary medical and remedial care not included in the plan.

(c) Expenses for necessary medical and remedial care included in the plan.

___ Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below.

1902(a)(17) of the Act

Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

Citation	Condition or Requirement
1903(f)(2) of the Act	a. Medically Needy (Continued) X (3) If countable income exceeds the MNIL standard, the agency deducts spenddown payments made to the State by the individual.

Citation	Condition or Requirement
	b. Categorically Needy - Section 1902 (f) States
42 CFR 435.732	The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income: (1) Any SSI benefit received. (2) Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act. (3) Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section. (4) Other deductions from income described in this plan at Attachment 2.6-A, Supplement 4. (5) Incurred expenses for necessary medical and remedial services recognized under State law.
1902(a)(17) of the Act, P.L. 100-203	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

Citation	Condition or Requirement
	4.b. Categorically Needy - Section 1902(f) States Continued
1903(f)(2) of the Act	X (6) Spenddown payments made to the State by the individual.
	NOTE: FFP will be reduced to the extent a State is paid a spenddown payment by the individual.

Citation	Condition or Requirement

5. Methods for Determining Resources

a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).

(1) In determining countable resources for AFDC-related individuals, the following methods are used:

(a) The methods under the State's approved AFDC plan; and

X (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

(2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

Citation	Condition or Requirement

5. Methods for Determining Resources

1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r) of the Act

b. Aged individuals. For aged individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, the agency used the following methods for treatment of resources:

___ The methods of the SSI program.

___ SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

X Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.

Citation	Condition or Requirement
	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and 1902(r) of the Act	c. Blind individuals. For blind individuals the agency uses the following methods for treatment of resources: ___ The methods of the SSI program. ___ SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A. X Methods that are more restrictive and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describe the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specify the more liberal methods. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State: MINNESOTA

Citation		Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r)(2) of the Act	d.	Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act. The agency uses the following methods for the treatment of resources: ___ The methods of the SSI program. ___ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. _X_ Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal that those under the SSI program. More restrictive methods are described in Supplement 5 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8b to ATTACHMENT 2.6-A. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
~~1902(l)(3) and 1902(r)(2) of the Act~~	~~e.~~	~~Poverty level pregnant women covered under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX)(A) of the Act.~~ ~~The agency uses the following methods in the treatment of resources.~~ ___ ~~The methods of the SSI program only.~~ ___ ~~The methods of the SSI program and/or any more liberal methods described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.~~

State: MINNESOTA

Citation	Condition or Requirement
	~~___ Methods that are more liberal than those of SSI. The more liberal methods are specified in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.~~
	~~X Not applicable. The agency does not consider resources in determining eligibility.~~
	~~In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.~~
1902(l)(3) and 1902(r)(2) of the Act	f. Poverty level infants covered under section 1902(a)(10)(A)(i)(IV) of the Act.
	~~The agency uses the following methods for the treatment of resources:~~
	~~___ The methods of the State's approved AFDC plan.~~
1902(l)(3)(C) of the Act	~~___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(l)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A.~~
1902(r)(2) of the Act	~~___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.~~
	~~X Not applicable. The agency does not consider resources in determining eligibility.~~

State: MINNESOTA

Citation		Condition or Requirement
1902(l)(3) and l902(r)(2) of the Act	g.	~~1. Poverty level children covered under sections 1902(a)(10)(A)(i)(VI), and 1902 (a)(10)(A)(ii)(IX) of the Act.~~ ~~The agency uses the following methods for treatment of resources:~~ ___ ~~The methods of the State's approved~~ AFDC ~~plan.~~
1902(l)(3)(C) of the Act	___	~~Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(l)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A.~~
1902(r)(2) of the Act	___	~~Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8b to ATTACHMENT 2.6-A.~~
	~~X~~	~~Not applicable. The agency does not consider resources in determining eligibility.~~ ~~In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.~~

State: MINNESOTA

Citation	Condition or Requirement
1902(l)(3) and 1902(r)(2) of the Act	g. 2. ~~Poverty level children covered under section 1902(a)(10)(A)(i)(VII~~
	~~The agency uses the following methods for treatment of resources:~~
	___ ~~The methods of the State's approved AFDC plan.~~
1902(l)(3)(C) of the Act	___ ~~Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(l)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A.~~
1902(r)(2) of the Act	___ ~~Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8b to ATTACHMENT 2.6-A.~~
	~~X~~ ~~Not applicable. The agency does not consider resources in determining eligibility.~~
	~~In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.~~

Citation	Condition or Requirement
1905(p)(1)(C) and (D) and 1902(r)(2) of the Act	5. h. For Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act the agency uses the following methods for treatment of resources: ___ The methods of the SSI program only. X The methods of the SSI program and/or more liberal methods as described in Supplement 8b to ATTACHMENT 2.6-A.
1905(s) of the Act	i. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.
1902(u) of the Act	j. For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources: ___ The methods of the SSI program only. ___ More restrictive methods applied under section 1902(f) of the Act as described in Supplement 5 to Attachment 2.6-A.

Citation	Condition or Requirement
1902(a)(10)(E)(iii) of the Act	k. Specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act-- The agency uses the same method as in 5.h. of Attachment 2.6-A.

6. Resource Standard - Categorically Needy

a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:

X Same as SSI resource standards.

___ More restrictive.

The resource standards for other individuals are the same as those in the related cash assistance program.

b. Non-1902(f) States (except as specified under items 6.c. and d. below)

The resource standards are the same as those in the related cash assistance program.

Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.

State: MINNESOTA

Citation		Condition or Requirement
1902(l)(3)(A), (B) and (C) of the Act	~~c.~~	~~For pregnant women and infants covered under the provisions of section 1902(a)(10)(A)(i)(IV) of the Act, the agency applies a resource standard.~~ ~~____ Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which, for pregnant women is no more restrictive than the standard under the SSI program; and for infants is no more restrictive than the standard applied in the State's approved AFDC plan.~~ ~~_X_ No. The agency does not apply a resource standard to these individuals.~~
1902(l)(3)(A) and (C) of the Act	~~d.~~	~~For children covered under the provisions of section 1902(a)(10)(A)(i)(VI) and section 1902(a)(10)(A)(i)(VII) of the Act, the agency applies a resource standard.~~ ~~Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan.~~ ~~_X_ No. The agency does not apply a resource standard to these individuals.~~

Citation	Condition or Requirement
1902(m)(1)(C) and (m)(2)(B) of the Act	e. For aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under section 1902(a)(10)(A)(ii)(X) of the Act, the resource standard is: ___ Same as SSI resource standards. ___ Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy). Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals. N/A

Citation	Condition or Requirement

7. Resouree Standard -- Medically Needy

a. Resource standards are based on family size.

1902(a)(10)(C)(i) of the Act

b. A single standard is employed in determining resource eligibility for all groups/

_____ c. In 1902(f) States, the resource standards are more restrictive than in 7(b) above for --

_____ Aged
_____ Blind
_____ Disabled

Supplement 2 to Attachment 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7(c), Supplement 2 so indicates.

1905(p)(1)(~~D~~ C) and (~~p~~)(~~2~~)(~~B~~) 1860D-14(a)(3)(D)

8. Resource Standard – Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries, and Qualifying Individual beneficiaries.

For qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act and specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, and Qualifying Individual beneficiaries, the resource standard is ~~twice~~ three times the SSI standard, adjusted annually by the increase in the consumer price Index.

1905(s) of the Act

9. Resource Standard – Qualified and Working Individuals

For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individuals or a couple (in the case of an individual with a spouse) is twice the SSI resource standard.

Citation		Condition or Requirement
1902(u) of the Act	9.1	For COBRA continuation beneficiaries, the resource standard is:
	___	Twice the SSI resource standard for an individual.
	___	More restrictive standard as applied under section 1902(f) of the Act as described in Supplement 8 to Attachment 2.6-A.

Citation	Condition or Requirement
1902(u) of the Act	10. Excess Resources a. Categorically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries Any excess resources make the individual ineligible. b. Categorically Needy Only ___ This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources. c. Medically Needy Any excess resources make the individual ineligible.

Citation	Condition or Requirement

42 CFR 435.914

11. Effective Date of Eligibility

a. Groups Other Than Qualified Medicare Beneficiaries

(1) For the prospective period.

Coverage is available for the full month if the following individuals are eligible at any time during the month.

X Aged, blind, disabled.
X AFDC-related.

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

___ Aged, blind, disabled.
___ AFDC-related.

(2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

X Aged, blind, disabled.
X AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied..

X Aged, blind, disabled.
X AFDC-related.

State: MINNESOTA

Citation	Condition or Requirement
1920(b)(1) of the Act	___ ~~(3) For a presumptive eligibility for pregnant women only.~~ ~~Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income eligibility levels specified in Attachment 2.6-A of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.~~
1902(e)(8) and 1905(a) of the Act	_X_ e. For qualified Medicare beneficiaries defined in section 1905(p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1). The eligibility determination is valid for -- __ 12 months _X_ 6 months __ ___ months (no less than 6 months and more than 12 months)

Citation		Condition or Requirement
1902(a)(18) and 1902(f) of the Act	12.	Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources. Disposal of resources at less than fair market value affects eligibility for certain services as detailed in Supplement 9 to ATTACHMENT 2.6-A.

C1

Citation	Condition or Requirement
1924 of the Act	13. The agency complies with the provisions of §1924 with respect to income and resource eligibility and post-eligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community. When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is: __X__ the maximum standard permitted by law; _____ the minimum standard permitted by law; or __X__ a standard that is an amount between the minimum and the maximum. ~~The State has a minimum protected resource amount for the community spouse of $22,828, which is greater than the minimum allowance in §1924, and is also subject to annual increases by the Consumer Price Index for urban consumers. The State also applies the maximum protected resource amount for the community spouse, currently at $80,760~~. In determining asset eligibility for the institutionalized spouse, eligibility may be approved under a waiver granted for undue hardship if, based on an individualized review of the case: The institutionalized spouse has excess assets above the asset standard for one person plus the maximum community spouse resource allowance, is not able to use those assets without the consent of the community spouse, and A denial of eligibility would cause an undue hardship by creating an imminent threat to the health or well-being of the institutionalized spouse;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Minnesota

Income Eligibility Levels

~~A. MANDATORY CATEGORICALLY NEEDY~~

~~1. AFDC-Related Groups Other than Poverty-Level Pregnant Women, Infants, and Children:~~

Number of Children in Grant	Children Only		Plus One Adult		Plus Two Adults		Children Only Where Special Children Standard Applies	
	NEED AND PAYMENT STANDARD							
	~~AFDC baseline - 7/16/96~~	~~**'1931 increase - 7/1/00**~~	~~AFDC baseline - 7/16/96~~	~~**'1931 increase - 7/1/00**~~	~~AFDC baseline - 7/16/96~~	~~**'1931 increase - 7/1/00**~~	~~AFDC baseline - 7/16/96~~	~~**'1931 increase - 7/1/00**~~
~~1~~	~~$ 250~~	~~**$ 258**~~	~~$ 437~~	~~**$ 451**~~	~~$ 510~~	~~**$ 526**~~	~~$ 337~~	~~**$ 348**~~
~~2~~	~~345~~	~~**356**~~	~~532~~	~~**548**~~	~~605~~	~~**624**~~	~~437~~	~~**451**~~
~~3~~	~~434~~	~~**448**~~	~~621~~	~~**640**~~	~~694~~	~~**715**~~	~~532~~	~~**548**~~
~~4~~	~~510~~	~~**526**~~	~~697~~	~~**718**~~	~~770~~	~~**794**~~	~~621~~	~~**640**~~
~~5~~	~~586~~	~~**604**~~	~~773~~	~~**797**~~	~~846~~	~~**872**~~	~~697~~	~~**718**~~
~~6~~	~~663~~	~~**683**~~	~~850~~	~~**876**~~	~~923~~	~~**951**~~	~~773~~	~~**797**~~
~~7~~	~~729~~	~~**751**~~	~~916~~	~~**944**~~	~~989~~	~~**1019**~~	~~850~~	~~**876**~~
~~8~~	~~793~~	~~**817**~~	~~980~~	~~**1010**~~	~~1053~~	~~**1085**~~	~~916~~	~~**944**~~
~~9~~	~~848~~	~~**874**~~	~~1035~~	~~**1067**~~	~~1108~~	~~**1142**~~	~~980~~	~~**1044**~~
~~10~~	~~902~~	~~**930**~~	~~1089~~	~~**1122**~~	~~1162~~	~~**1197**~~	~~1035~~	~~**1067**~~
~~Each additional child~~	~~+ 53~~	~~**+ 55**~~	~~+ 53~~	~~**+ 55**~~	~~+ 53~~	~~**+ 55**~~	~~+ 53~~	~~**+ 55**~~

First Adult Standard: $193
Second Adult Standard: 75
One Child Only Special Standard: 348
Special Adult Standard: 258

~~2. Pregnant Women and Infants under Section 2901(a)(10)(i)(IV) of the Act~~

~~Effective April 1, 1990, based on the following percent of the official Federal income poverty line~~

[ ] 133 percent ~~[X] 185 percent (no more than 185 percent)~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Minnesota

Income Eligibility Levels

~~A. MANDATORY CATEGORICALLY NEEDY (Continued)~~

~~3. For children under Section 1902(a)(10)(i)(VI) of the Act (children who have attained age 1 but have not attained age 6), the income eligibility level is 133 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.~~

~~4. For children under Section 1902(a)(10)(i)(VII) of the Act (children who were born after September 30, 1983 and have attained age 6 but have not attained age 19), the income eligibility level is 100 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Minnesota

Income Eligibility Levels (Continued)

B. ~~OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL:~~

~~2. Pregnant Women and Infants~~

~~The levels for determining income eligibility for optional groups of pregnant women and infants under the provisions of section 1902(a)(10)(A)(ii)(IX) and 1902(l)(2) of the Act are as follows:~~

~~Based on _____ percent of the official Federal income poverty level (no less than 133 percent and no more than 185 percent).~~

Family Size	Income Level
1	$
2	$
3	$
4	$
5	$

~~NOT APPLICABLE. THIS GROUP IS NOT COVERED.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Minnesota

Income Eligibility Levels (Continued)

B. ~~OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL:~~

~~2.~~ ~~Children Between Ages 6 and 8~~

~~The levels for determining income eligibility for groups of children who are born after September 30, 1983 and who have attained 6 years of age but are under 8 years of age under the provisions of section 1902(l)(2) of the Act are as follows:~~

~~Based on _____ percent no more than 100 percent) of the official Federal income poverty line.~~

Family Size	Income Level
1	$
2	$
3	$
4	$
5	$
6	$
7	$
8	$
9	$
10	$

~~NOT COVERED.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Minnesota

Income Eligibility Levels (Continued)

3. Aged and Disabled Individuals:

/X/ The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1902(m)(4) of the Act are as follows:

Based on 95 percent of the official Federal income poverty line.

Family Size	Income Level
1	$ 683
2	$ 920
3	$ 1,159
4	$ 1,398
5	$ 1,637
6	$ 1,876
7	$ 2,115
8	$ 2,354
9	$ 2,594
10	$ 2,831

If an individual receives title II benefits, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level .

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.

42 CFR 435.236
42 CFR 435.1005

4. Institutionalized Individuals Under a Special Income Standard:

/X/ The level of income is equal to 300 percent of the SSI benefit amount payable under section 1611(b)1) of the Act to an individual in his own home who has no income or resources.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

D. MEDICALLY NEEDY

[ ] Applicable to all groups.

[X] Applicable to aged, blind, and disabled groups.

[ ] Applicable to all groups except those specified below. Excepted group income levels are also listed on an attached page 3.

1	2	3	4	5
Family Size	Net Income Level Protected for Maintenance for 1 months [ ] urban only [X] urban & rural	Amount by Which Column (2) Exceeds Limits Specified in 42 CFR 435.1007[1]	Net Income Level for Persons Living in Rural Areas for _ months	Amount by which column (4) exceeds limits specified in 42 CFR 435.1007[1]
1	$ 482			
2	602			
3	731			
4	854			
5	957			
6	1,063			
7	1,168			
8	1,259			
9	1,347			
10	1,423			

For each additional person add: $ 74

The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

MEDICALLY NEEDY

[ ] Applicable to all groups.

[X] Applicable to families with children.

[] Applicable to all groups excepts those specified below. Excepted group income levels are also listed on an attached page 3.

1	2	3	4	5
Family Size	Net Income Level Protected for Maintenance for 1 months [ ] urban only [x] urban & rural	Amount by Which Column (2) Exceeds Limits Specified in 42 CFR 435.1007[1]	Net Income Level for Persons Living in Rural Areas for _ months	Amount by which column (4) exceeds limits specified in 42 CFR 435.1007[1]
1	$ 482			
2	602			
3	731			
4	854			
5	957			
6	1,063			
7	1,168			
8	1,259			
9	1,347			
10	1,423			

For each additional person add: $ 74

The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

RESOURCE LEVELS

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

~~1. Pregnant Women~~

~~a. Mandatory Groups~~

// ~~Same as SSI resources levels.~~

/X/ ~~Less restrictive than SSI resource levels and is as follows:~~

~~Family Size~~	~~Resource Level~~
1	~~No resource test applied.~~
2	

~~b. Optional Groups [Not covered]~~

// ~~Same as SSI resources levels.~~

// ~~Less restrictive than SSI resource levels and is as follows:~~

Family Size	Resource Level
1	
2	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

~~3. Children~~

~~a. Mandatory Group of Infants~~

/_/ ~~Same as resource levels in the State's approved AFDC plan.~~

~~/X/ Less restrictive than the AFDC levels and are as follows:~~

~~Family Size~~	~~Resource Level~~	
1		
2		~~No asset test applied.~~
3		
4		
5		
6		
7		
8		
9		
10		

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

~~b. Optional Group of Infants~~

/_/ ~~Same as resource levels in the State's approved AFDC plan.~~

~~/x/ Less restrictive than the AFDC levels and are as follows:~~

Family Size	Resource Level	
1		~~Not covered.~~
2		
3		
4		
5		
6		
7		
8		
9		
10		

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

~~3. Children~~

~~a. Mandatory Group of Children~~

/_/ ~~Same as resource levels in the State's approved AFDC plan.~~

/X/ ~~Less restrictive than the AFDC levels and are as follows:~~

Family Size	Resource Level	
1		
2		~~No asset test applied.~~
3		
4		
5		
6		
7		
8		
9		
10		

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

b. Optional Group of Children

☐ ~~Same as resource levels in the State's approved AFDC plan~~

~~X Less restrictive than the AFDC levels and are as follows:~~

~~No resource test is applied to the following optional groups of children listed in Attachment 2.2-A:~~

~~B.7.a. Children under age 21 who meet AFDC requirements;~~

B.7.b. Other reasonable classifications of optional groups of children described in Supplement 1 to Attachment 2.2-A;

~~B.8. Children under age 21 who are under an adoption assistance agreement;~~

~~B.19. Optional Targeted Low-income Children~~

Revision: HCFA-PM-91-4 (BPD)
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

4. Aged and Disabled Individuals

___ Same as SSI resources levels

___ More restrictive than SSI resource levels and are as follows:

Family Size	Resource Level
1	___
2	___

_X_ Same as aged, blind and disabled medically needy resource levels.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

RESOURCE LEVELS (continued)

B. MEDICALLY NEEDY

1. Applicable to aged, blind and disabled groups - /X/ Except those specified below.

Family Size	Resource Level
1	$3750
2	6450

Note: No resource test is applied to medically needy groups of children listed in Attachment 2.2-A. See Supplement 8b to Attachment 2.6-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Minnesota

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

Post-eligibility Treatment of Institutionalized Individuals' Income Under B.3.c(ii) or B.4.d(ii) of Attachment 2.6-A:

[NOTE : B(3)(c) applies to an institutionalized person with a community spouse and B(4)(d) applies to amounts for health care expenses not deducted in B(3) incurred by and for an institutionalized person or institutionalized couple]

The state limits reasonable expenses for necessary medical or remedial care that are recognized under state law, but not covered under the Medicaid State Plan and not subject to payment by a third party, to the following:

1. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.
2. A deduction for the amount of an expense not previously used as a deduction from income.
3. A deduction is limited to bills incurred within three months before the month of application.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

METHODS FOR TREATMENT OF INCOME THAT DIFFER FROM THOSE OF THE SSI PROGRAM

Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section 1902(r)(2) of the Act. Use Supplement 8a for section 1902(r)(2) methods.)

Policies that apply in determining income eligibility:

- The categorically and medically needy income standards for aged, blind, and disabled are lower than the SSI income standards.
- Veterans' aid and attendance benefits are considered income for categorically and medically needy aged, blind and disabled.
- Unusual medical expense payments by the Veterans Administration are considered income to categorically needy and medically needy aged, blind and disabled.
- The standard income disregard of $20 is not applied to categorically needy and medically needy aged, blind and disabled.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

MORE RESTRICTIVE METHODS OF TREATING RESOURCES
THAN THOSE OF THE SSI PROGRAM - Section 1902(f) States only

Homestead exclusion for institutionalized persons. The homestead shall be excluded for the first six calendar months of a person's stay in a long-term care facility and shall continue to be excluded for as long as the recipient can be reasonably expected to return to the homestead. The term "reasonably expected to return to the homestead" means the recipient's attending physician has certified that the expectation is reasonable, and the recipient can show that the cost of care upon returning home will be met through medical assistance or other sources.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS
WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

Revision: October 1, 1984

SUPPLEMENT 6 TO
Attachment 2.6-A

STATE: MINNESOTA

Standards for Optional State Supplementary Payments

Minnesota Supplemental Assistance and Group Residential Housing Program						
Payment Category (Reasonable Classification)	**Administered by Federal or State**	**Income Level**				**Income Disregards Employed**
		Gross		**Net**		
		1 Person	**Couple**	**1 Person**	**Couple**	
Disabled and age 18 or older. Age 65 or older. Blind.	State	300% of the SSI benefit rate for an individual. -7/1/93 = $1,302 -1/1/94 = 1,338 -1/1/95 = 1,374	600% of the SSI benefit rate for an individual. -7/1/93 = $2,604 -1/1/94 = 2,676 -1/1/95 = 2,748	**Client living in GRH:** -7/1/93=$976.37 for client who entered GRH agreement prior to 6/1/89); $879.73 for client who entered GRH agreement on or after 6/1/89. -1/1/94=$987.37 -1/1/95=$1001.37 **Client living alone:** -7/1/93 = $495 + *. -1/1/94 = $507 + *. -1/1/95 = $519 + *.	**Married couple who are both found eligible for MSA before 1/1/94 & who do not live w/others:** -7/93= $758+*. -1/94= $775+*. -1/95= $793+*. **Married couple who are both found eligible for MSA on or after 1/1/94 & who do not live with others:** -1/94= $760+*. -1/95= $778+*.	**For clients living in a LTC facility with the cost of care paid for by Medicaid:** • $80 earned income disregard. • Disregard of earned income expenses. • Guardianship fees to a legally-appointed guardian or conservator. Allow up to 5% of client's monthly gross income to a maximum of $100. • Allocations to spouse or children under age 18 who are neither institutionalized nor receiving AFDC. **For all other clients:** • Earned income disregard of $400 per month to a maximum of $1,620 per calendar year for blind or disabled student children under age 22.

HCFA-179 # 93-032 Date Rec'd _____

Supercedes _____ Date Appr. MAR 15 1996

State Rep. In _____ Date Eff. 7-1-93

Minnesota Supplemental Assistance and Group Residential Housing Program

Payment Category (Reasonable Classification)	Administered by Federal or State	Income Level				Income Disregards Employed
		Gross		Net		
		1 Person	Couple	1 Person	Couple	
				Client living with others: -7/1/93 = $397 + *. -1/1/94 = $387 + *. -1/1/95 = $395 + *. **Client in medical facility where cost of care is paid by MA; Blind child who lives with parents & is ineligible for SSI because parent's income is counted, who received a personal needs allowance when in a Title XIX facility & receives MA under home & community based waivers.** -7/93 = $56 -1/94 = $57 -1/95 = $59	**Married couple who are both found eligible for MSA before 1/1/94 & who live with others:** -7/93= $758+*. -1/94= $770+*. -1/95= $782+*. **Married couple who are both found eligible for MSA on or after 1/1/94 & who live with others:** -1/94= $507+*. -1/95+ $519+*.	• $20 standard disregard. • The 1st $65 plus half of the remaining earned income disregard. (If both spouses are clients, apply disregard to each client.) • Work expense deduction for disabled clients. • One-half the remaining earned income. • Work expense deduction for blind clients. • Allocations to spouse or children under age 18 who are neither institutionalized nor receiving AFDC. • Income used to fulfill an approved Plan to Achieve Self Support (PASS) for disabled clients

*** Amount allowed for on-going, special needs.**

HCFA-179 # 93-032 Date Rec'd MAR 15 1996

Supercedes ——— Date Appr. ———

State Rep. In ——— Date Eff. 7-1-93

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

INCOME LEVELS FOR 1902(f) STATES - CATEGORICALLY NEEDY
WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

SAME AS MEDICALLY NEEDY INCOME LEVELS CONTAINED IN SUPPLEMENT 1 OF THIS ATTACHMENT.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

RESOURCE STANDARDS FOR 1902(f) STATES - CATEGORICALLY NEEDY

SAME AS SSI.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MINNESOTA
MORE LIBERAL METHODS OF TREATING INCOME
UNDER § 1902(r)(2) OF THE ACT
*[More liberal methods may not result in exceeding gross income limitations under § 1903(f).]
[X] §1902(f) State [ ] Non-§1902(f) State

Policy	How Policy is More Liberal	Groups to Which Policy Is Applied
Widow or widower(s) disregard. Disregard all RSDI cost of living increases effective January 1, 1984 or later for individuals who meet requirements of §1634(d).	SSI has no similar disregard.	Qualified medicare beneficiaries. §1902(a)(10(E)(i). Specified low-income medicare beneficiaries. §1902(a)(10)(E)(iii). Qualifying individuals. §1902(a)(10)(E)(iv).
Pickle disregard. Pickle amendment disregard of RSDI cost of living adjustments.	SSI has no similar disregard.	Qualified medicare beneficiaries. §1902(a)(10(E)(i). Specified low-income medicare beneficiaries. §1902(a)(10)(E)(iii). Qualifying individuals. §1902(a)(10)(E)(iv).
Disabled adult children disregard. Disregard RSDI benefits of disabled adult children who meet requirements of §1634.	SSI has no similar disregard.	Qualified medicare beneficiaries. §1902(a)(10(E)(i). Specified low-income medicare beneficiaries. §1902(a)(10)(E)(iii). Qualifying individuals. §1902(a)(10)(E)(iv).
COLA delay disregard. Disregard the annual RSDI eost of living adjustment from January 1 through June 30th of each year.	SSI has no similar disregard.	Qualified medicare beneficiaries. §1902(a)(10(E)(i). Specified low-income medicare beneficiaries. §1902(a)(10)(E)(iii). Qualifying individuals. §1902(a)(10)(E)(iv).
§1619(a) and (b) disregard. Disregard income of individuals deemed to be an SSI recipient under §1619(a) or (b).	SSI has no similar disregard.	Qualified medicare beneficiaries. §1902(a)(10(E)(i). Specified low-income medicare beneficiaries. §1902(a)(10)(E)(iii). Qualifying individuals. §1902(a)(10)(E)(iv).
Community spouse and family allowance disregard. Disregard community spouse monthly income allowance and family allowance as defined at §1924(d)(2) and (3) to the extent it is made available to the community spouse and family.	SSI has no similar disregard.	Qualified medicare beneficiaries. §1902(a)(10(E)(i). Specified low-income medicare beneficiaries. §1902(a)(10)(E)(iii). Qualifying individuals. §1902(a)(10)(E)(iv).
In-kind income for elderly, blind and disabled. Disregard in-kind income.	SSI has no similar disregard.	Elderly and disabled who meet more restrictive criteria under §1902(f) and an income level under §§1902(a)(10)(A)(ii)(X) and 1902(m). Optional categorically needy disabled children under 18. §§ 1902(a)(10)(A)(ii)(X), 1905(a)(i). Medically needy disabled children under 18. §§1905(a)(i) and 1902(a)(10)(C). Optional categorically needy children under age 21 who would be institutionalized but for HCB services. §§1902(a)(10)(A)(ii)(X), 1905(a)(i) and 1915(c) Qualified medicare beneficiaries. §1902(a)(10(E)(i). Specified low-income medicare beneficiaries. §1902(a)(10)(E)(iii). Qualifying individuals. §1902(a)(10)(E)(iv).

POLICY	HOW POLICY IS MORE LIBERAL	GROUPS TO WHICH POLICY IS APPLIED
~~**Pregnant women and infants disregard.** For families with earned income only, the State will disregard income in the amount of 90% of the federal poverty level for the size family involved as revised annually in the *Federal Register* rather than the $90 disregard plus the following amounts:~~ ~~Household Size — Disregard~~ ~~1 — $136~~ ~~2 — 140~~ ~~3 — 145~~ ~~4 — 149~~ ~~5 — 156~~ ~~6 — 161~~ ~~7 — 165~~ ~~8 — 170~~ ~~9 — 177~~ ~~10 — 181~~ ~~Each add'l person — 5~~ ~~For families with unearned income only, the State will disregard income in the amount of 90% of the federal poverty level for the size family involved as revised annually in the *Federal Register*~~	~~AFDC applies earned income disregards of $30 plus 1/3 of the remainder and $90.~~	~~Pregnant women and infants poverty level group. § 1902(a)(10)(A)(i)(IV).~~
SSI recipient disregard. Disregard income of SSI recipients up to an amount that is the difference between the income standard and the federal benefit rate.	SSI has no similar disregard.	Individuals who meet more restrictive requirements than SSI. §1902(f)
~~**Income disregard.** Disregard the difference between former AFDC standards in effect on 7/16/96 and the income standards for the §1931 group.~~	~~No similar disregard in Title XIX.~~	~~1902(a)(10)(A)(i)(III) and 1905(n)~~ ~~1902(a)(10)(A)(ii)(I) and 1905(a)(i)~~ ~~1902(a)(10)(A)(ii)(IV) and 1905(a)(i)~~ ~~1902(a)(10)(A)(ii)(VIII) and 1905(a)(i)~~ ~~1905(a)(10)(A)(ii)(XIV) and 1905(a)(i)~~ ~~1902(a))10)(C)(i)(III) and 1905(a)(i) and (a)(ii), (a)(ix)~~
Census Income disregard. Disregard earned income of temporary census employees who were recipients in Minnesota health care programs on or before March 1, 2000.	SSI and AFDC have no similar disregard.	All mandatory and optional categories in the Medicaid State Plan not subject to the limitation on FFP in section 1903(f) of the Act.

POLICY	HOW POLICY IS MORE LIBERAL	GROUPS TO WHICH POLICY IS APPLIED
~~**Children ages one through five disregard.** For families with earned income only the State will disregard income in the amount of 142% of the federal poverty level for the size family involved as revised annually in the *Federal Register* minus $90. For families with unearned income only, the State will disregard income in the amount of 142% of the federal poverty level for the size family involved as revised annually in the *Federal Register*. This methodology is effective July 1, 1995.~~	~~AFDC has no similar disregard.~~	~~Children ages one through five. §1902(a)(10)(i)(VI).~~
~~Children age six or more disregard. For families with earned income only, the State will disregard income in the amount of 175% of the federal poverty level for the size family involved as revised annually in the *Federal Register* minus $90. For families with unearned income only, the State will disregard income in the amount of 175% of the federal poverty level for the size family involved as revised annually in the *Federal Register*. This methodology is effective July 1, 1995.~~	~~AFDC has no similar disregard~~	~~Children age six or more, born after September 30, 1983. §1901(a)(10)(A)(i)(VII).~~
~~Qualified children disregard. For families with earned income only, the State will disregard income in the amount of the difference between 100% of the AFDC standard and 275% of the federal poverty level for the size family involved as revised annually in the *Federal Register* minus $90. For families with unearned income only, the State will disregard income in the amount of the difference between 100$ of the AFDC standard and 275% of the federal poverty level for the size family involved as revised annually in the *Federal Register*. This methodology is effective July 1, 1995.~~	~~AFDC has no similar disregard~~	~~Qualified children. §1902(a)(10)(A)(i)(III).~~

POLICY	HOW POLICY IS MORE LIBERAL	GROUPS TO WHICH POLICY IS APPLIED
Add'l ABD Income Disregard. Effective July 1, 2001 through June 30, 2002, disregard the difference between the individual's income in excess of the income standard in Supplement 1 to Attachment 2.6-A, page , and 70 percent of the federal poverty levels by family size based on federal poverty levels in effect on July 1, 2001. Effective July 1, 2002, disregard the difference between the individual's income in excess of the income standard in Supplement 1 to Attachment 2.6-A, page , and 75 percent of the federal poverty levels by family size, based upon revised federal poverty levels for calendar year 2002. Thereafter adjust the disregard on each July 1 based on revised federal poverty levels published for the calendar year. Effective July 1, 2016, disregard the difference between the individual's income in excess of the income standard in Supplement 1 to Attachment 2.6-A, page 7, and 80 percent of the federal poverty levels by family size, based upon revised federal poverty levels for 2016. Adjust the disregard on July 1 in each subsequent year based on revised federal poverty levels published for the calendar year.	SSI has no similar disregard.	Eligibility groups under the following sections of the act:<br ~~§1902(f)~~ §§1902(a)(10)(C) and 1905(a)(iii)(iv) and (v). ~~§§1902(e), 1905(a)(i) and 1902(a)(10)(C) (medically needy reasonable classification of TEFRA children).~~ ~~§§1905(a)(i), 1915(e), 1902 (a)(10)(C) (medically needy reasonable classification of disabled children under age 21 who would be institutionalized but for HCB services under a §1915(e) waiver).~~ Reasonable Classification of children on page 1 of Supplement 1 to Attachment 2.2-A, item C.5(b)(6)
COLA delay disregard. Disregard the annual RSDI cost of living adjustment from January 1 through June 30th of each year.	SSI has no similar disregard.	Eligibility groups under the following sections of the act: §1902(f) §1902(a)(10)(C) and 1905(a)(iii)(iv) and (v). ~~§§1902(e), 1905(a)(i) and 1902(a)(10)(C); (medically needy disabled children).~~ ~~§§1905(a)(i), 1915(e), 1902 (a)(10(C); (medically needy disabled children under age 21 who would be institutionalized but for HCB services under a §1915(e) waiver).~~ Reasonable Classification of children on page 1 of Supplement 1 to Attachment 2.2-A, item C.5(b)(6)
Disregard for Elderly and Disabled Under §1902(m). Effective July 1 through June 30 of the following year, disregard the difference between the income standard and 100 percent of the federal poverty levels, using 100 percent of federal poverty levels in effect on July 1 of each 12 month period. The income standard will be adjusted in the first month after the publication of the revised federal poverty levels for the calendar year. The disregard will be adjusted on the basis of revised federal poverty levels for the calendar year on each July 1.	SSI has no similar disregard.	Eligibility groups under the following sections of the act: §1902(f) §§1902(a)(10)(A)(ii)(X) and 1902(m). §§ 1902(a)(10)(A)(ii)(X), 1902(e), 1905(a)(i); (optional categorically needy disabled children under 19). §§1902(e), 1905(a)(i) and 1902(a)(10)(C); (medically needy disabled children under 19). §§ 1902(a)(10)(A)(ii)(X), 1905(a)(i) and 1915(c); (optional categorically needy children under age 21 who would be institutionalized but for HCB services).
Income Disregard for Certain Children. Disregard child support payments received, and social security payments received under Title II	SSI has no similar disregard.	Eligibility groups under the following sections of the act: §§1902(a)(10)(A)(ii)(X), 1902(e), 1902(m) 1905(a)(i); (optional categorically needy disabled children under 19). §§1902(a)(10)(C), 1902(e), 1905(a)(i); (medically needy disabled children). §§1902(a)(10)(A)(ii)(X), 1902(m), 1905(a)(i) and 1915(c); (optional categorically needy children under age 21 who would be institutionalized but for HCB services). §§1902 (a)(10(C), 1905(a)(i), 1915(c); (.medically needy disabled children under age 21 who would be institutionalized but for HCB services;

POLICY	HOW POLICY IS MORE LIBERAL	GROUPS TO WHICH POLICY APPLIED
Income disregard for ~~categorically needy groups related to AFDC, and~~ medically needy related to AFDC. Disregard the difference between the applicable income standard (Supplement 1 to Attachment 2.6-A) and ~~100~~ 133 percent of the Federal poverty levels. Adjust annually on July 1.	AFDC applied a $50 child support exclusion and a $90 disregard of earned income. This income disregard replaces these two methods.	~~1902(a)(10)(A)(i)(III) and 1905(n).~~ ~~1902(a)(10)(A)(ii)(I), 1905(a)(i) and 1905(a)(ii).~~ ~~1902(a)(10)(A)(ii)(IV), 1905(a)(i) and (a)(ii)~~ ~~1902(a)(10)(A)(ii)(VIII), 1905(a)(i)~~ 1902(a)(10)(C)(i)(III), 1905(a)(i), (a)(ii) and (a)(viii).
Earned income disregard for ~~categorically needy groups and~~ the medically needy related to AFDC and medically needy, pregnant women and children. Disregard 17 percent of earned income for four months for applicants or recipients.	AFDC had no similar disregard for applicants. This disregard applies to applicants and recipients.	~~1902(a)(10)(A)(i)(III) and 1905(n)~~ ~~1902(a)(10)(A)(ii)(I), 1905(a)(i) and (a)(ii).~~ ~~1902(a)(10)(A)(ii)(IV), 1905(a)(i) and (a)(ii)~~ ~~1902(a)(10)(A)(ii)(VIII), 1905(a)(i)~~ 1902(a)(10)(C)(i)(III), 1905(a)(i), (a)(ii), (a)(viii)
~~**Income Disregard for certain poverty level children.** Disregard the difference between the income standard and income up to 150 percent of poverty. Adjust annually on July 1.~~	~~AFDC applied a $50 child support exclusion from income. This income disregard replaces this method.~~	~~Eligibility groups under the following sections of the Act~~ ~~1902(a)(10(A)(i)(VI)~~ ~~1902(a)(10)(A)(i)(VII).~~
Disregard for children. Disregard up to $2000 annually in cash gifts received from tax-exempt organizations for the benefit of a child with a life-threatening illness.	AFDC has no such disregard.	Eligibility groups under the following sections of the Act: ~~1902(a)(10)(A)(i)(III) and 1905(n)(2)~~ ~~1902(a)(10)(A)(i)(IV)~~ ~~1902(a)(10)(A)(i)(VI)~~ ~~1902(a)(10)(A)(i)(VII)~~ ~~1902(a)(10)(A)(ii)(I) and 1905(a)(i)~~ ~~1902(a)(10)(A)(ii)(IV) and 1905(a)(i)~~ ~~1902(a)(10)(A)(ii)(VIII) and 1905(a)(i)~~ ~~1902(a)(10)(A)(ii)(XIV) and 1905(a)(i)~~ 1902(a)(10)(C)(i)(III) and 1905(a)(i)

POLICY	HOW POLICY IS MORE LIBERAL	GROUPS TO WHICH POLICY IS APPLIED
Disregard of State Catastrophe Funds. Disregard Minnesota I-35 Catastrophe Relief Fund payments.	AFDC and SSI have no similar disregard.	Eligibility Groups under the following sections of the Act: ~~1902(a)(10)(A)(i)(III)~~ ~~1902(a)(10)(A)(i)(IV)~~ ~~1902(a)(10)(A)(i)(VI)~~ ~~1902(a)(10)(A)(i)(VII)~~ 1902(f) 1902(a)(10(A)(ii) (I) 1902(a)(10)(A)(ii)(IV) ~~1902(a)(10)(A)(ii) (VIII)~~ ~~1902(a)(10)(A)(ii) (IX)~~ 1902(a)(10)(A)(ii) (X) 1902(a)(10)(A)(ii) (XI) 1902(a)(10)(A)(ii) (XIV) 1902(a)(10)(A)(ii) (XV) QMB, SLMB & QI under 1902(a)(10)(E) and 1905(p). Medically needy groups under §1902(a)(10)(C).
Disregard under Court Order: Disregard payments to class members under the federal court order in Jensen *et al* v. Minnesota Department of Human Services, CN 09-1775 (DWF/FLN).	AFDC and SSI have no similar disregard.	Eligibility Groups under the following sections of the Act: ~~1902(a)(10)(A)(i)(III)~~ ~~1902(a)(10)(A)(i)(IV)~~ ~~1902(a)(10)(A)(i)(VI)~~ ~~1902(a)(10)(A)(i)(VII)~~ 1902(f) 1902(a)(10(A)(ii) (I) 1902(a)(10)(A)(ii)(IV) ~~1902(a)(10)(A)(ii) (VIII)~~ ~~1902(a)(10)(A)(ii) (IX)~~ 1902(a)(10)(A)(ii) (X) 1902(a)(10)(A)(ii) (XI) 1902(a)(10)(A)(ii) (XIV) 1902(a)(10)(A)(ii) (XV) QMB, SLMB & QI under 1902(a)(10)(E) and 1905(p). Medically needy groups under §1902(a)(10)(C).

POLICY	HOW POLICY IS MORE LIBERAL	GROUPS TO WHICH POLICY IS APPLIED
Employed disabled Disregard. In step one, disregard earned and unearned income of the employed disabled person, and other family members.	Eligibility for the working disabled person uses a net income family income test of 250% of the federal poverty level by family size after application of SSI income disregards and exemptions.	§1902(a)(10)(A)(ii)(XIII)
Employed Disabled Spouse Disregard. In step two, disregard all unearned income of the disabled person and do not deem earned and unearned income of the ineligible spouse to the employed disabled person.	Step two of the eligibility determination for the disabled person applies SSI income methods to determine if the individual would, but for earnings in excess of the limit in 1905(q)(2)(B), be eligible to received SSI benefits, including the deeming of income of the ineligible spouse to the disabled person.	1902(a)(10)(A)(ii)(XIII)

POLICY	HOW POLICY IS MORE LIBERAL	GROUPS TO WHICH POLICY IS APPLIED
Disregard under NIH study: Disregard from income any payments made to parents participating in the "income and child development in the first three years of life" demonstration project funded by the United States Department of Health and Human Services National Institutes of Health.	AFDC and SSI have no similar disregard.	Eligibility Groups under the following sections of the Act: 1902(f) 1902(a)(10(A)(ii) (I) 1902(a)(10)(A)(ii)(IV) 1902(a)(10)(A)(ii) (VI) 1902(a)(10)(A)(ii) (X) 1902(a)(10)(A)(ii) (XI) 1902(a)(10)(A)(ii) (XIII) QMB, SLMB & QI under 1902(a)(10)(E) and 1905(p). Medically needy groups under 1902(a)(10)(C).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MINNESOTA
MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER §1902(r)(2) OF THE ACT

POLICY	HOW POLICY IS MORE LIBERAL	GROUPS TO WHICH POLICY IS APPLIED
Auto exclusion. Exclude one vehicle for each person that uses a vehicle for employment or for seeking employment.	AFDC has an auto exclusion of $1,500.	Medically needy families with children. §§1902(a)(10)(C)(i)(III), ~~1905(a)(i)~~ and 1905(a)(ii).
Additional property disregard. Exclude $9,000 in property not subject to other exclusions for one person, and exclude $19,000 for two or more people.	AFDC applies a $1,000 asset limit to families.	Medically needy families with children. §§1902(a)(10)(C)(i)(III) and 1905(a)(ii)
Child assets. Exclude all assets established under the Uniform Gift to Minors Act, and the child-owned portion of an account held jointly by an adult and child.	AFDC has no similar property exclusion.	Medically needy families and children. §§1902(a)(10)(C)(i)(III), 1905(a)(i) and 1905(a)(ii).
Homestead exclusion. Exclude the homestead of a person residing in a long term care facility if it is used as the residence of the person's: ·Sibling who lived in the home for at least 1 year immediately before the date of the client's admission to the long term care facility and who has an equity interest in the home; or ·Adult child or grandchild who lived in the home for at least 2 years immediately before the date of the client's admission to the long term care facility and who provided verifiable care to the client to permit the client to live at home instead of the long term care facility.	SSI has no similar exclusion	Qualified medicare beneficiaries. §1902(a)(10)(E)(i). Qualified disabled working individuals. §1902(a)(10)(E)(ii). Specified low-income medicare beneficiaries. §1902(a)(10)(E)(iii). Qualified individuals. § 1902(a)(10)(E)(iv). Optional categorically needy -aged, blind, and disabled. §1902(a)(10)(A)(ii). Medically needy -aged, blind, and disabled. §1902(a)(10)(C)(i)(III).
Additional Asset Exclusion: For one child living with a disabled or elderly individual, exclude an additional $3,000, and $200 for each additional child; for each child living with a disabled or elderly couple, exclude an additional $200.	SSI has no such exclusions.	Mandatory categorically needy aged, blind and disabled under § 1902(f) Optional categorically needyaged, blind, and disabled. §1902(a)(10)(A)(ii). Medically needy -aged, blind, and disabled. §1902(a)(10)(C)(i)(III).
Resource Exclusion for Children. Exclude all resources.	~~AFDC has no similar exclusion~~. SSI has no similar exclusion	~~Qualified children. §1902(a)(10)(A)(I)(III).~~ All optional categorically needy children~~.~~ §1902(a)(10)(A)(ii)(I)and 1905(a)(i) §1902(a)(10)(A)(ii)(IV) and 1905(a)(i) ~~§1902(a)(10)(A)(ii)(VIII)~~ §1902(a)(10)(A)(ii)(XV) Medically needy children. §§1902(a)(10)(C)(i)(III), 1905(a)(i)
~~Resource Exclusion for Qualified Pregnant Women. Exclude all resources.~~	~~AFDC has no similar exclusion.~~	~~Qualified pregnant women. §1902(a)(10)(A)(i)(III)~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MINNESOTA
MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER §1902(r)(2) OF THE ACT

POLICY	HOW POLICY IS MORE LIBERAL	GROUPS TO WHICH POLICY IS APPLIED
Spouse Asset Exclusion. Do not count or deem assets of the ineligible spouse to the disabled person.	SSI deems assets of the ineligible spouse to the disabled applicant or recipient.	~~TWWIIA Basic Coverage Group.~~ §1902(a)(10)(A)(ii)(~~XV~~)(XIII).
Retirement/Medical Benefits Exclusion. Exclude the following assets of the employed disabled person: retirement accounts including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, pension plans, and medical expense accounts through the employer.	SSI has no similar exclusions.	~~TWWIIA Basic Coverage Group.~~ §1902(a)(10)(A)(ii~~)(XV)~~(XIII).
Additional Property Disregard: In step two, exclude $18,000 in nonexcluded assets.	SSI excludes $2,000 in nonexcluded assets for an individual.	§1902(a)(10)(A)(ii)(XIII).
Dual-eligible Property Exclusion. Disregard the difference between three times the SSI asset limit and $10,000 in nonexcluded assets for an individual, and the difference between three times the SSI asset limit and $18,000 for a couple..	SSI allows $2,000 in nonexcluded assets for an individual, and $3,000 for a couple; and Medicaid requires an asset standard of three times the SSI limit.	Qualified medicare beneficiaries §1902(a)(10)(E)(i). Specified low-income medicare beneficiaries §1902(a)(10)(E)(iii). Qualified Individuals §1902(a)(10)(E)(iv).
Transition Disregard for Disabled Individuals Who Were Working. For individuals who become ineligible ~~for the TWWIIA Basic Coverage Group~~ under §1902(a)(10)(A)(ii)~~(XV)~~(XIII) due to loss of earnings, and who qualify for Medicaid under another category, continue to disregard for 12 consecutive months the assets allowed and excluded under~~ the TWWIIA Basic Coverage Group,~~ §1902(a)(10)(A)(ii)~~(XV)~~(XIII).	SSI has no similar disregard	Mandatory categorically needy aged, blind and disabled using more restrictive criteria under §1902(f) Optional categorically needy aged and disabled groups~~.~~ §1902(a)(10)(A)(ii). Medically needy aged, blind, and disabled. §1902(a)(10)(C)(i)(III); and 1905(a) . ~~Families under~~ §1931 Medically needy families and children. §§1902(a)(10)(C)(i)(III), 1905(a)(i) and 1905(a)(ii). Reasonable categories of children in Supplement 1 to Attachment 2.2-A. §§1905(a)(i), 1902(e), 1902(m), 1902(a)(10)(C)(i)(III), 1915(c) and 1905(a)(i).
Retirement Assets. Exclude IRA's, 401(k) plans, 403(b) plans, Keogh plans and other individually-owned pension and retirement funds.	AFDC has no similar property exclusion.	Optional categorically needy: §§1902(a)(10)(A)(ii)(I), 1905(a)(i) and 1905(a)(ii). §§1902(a)(10)(A)(ii)(IV) and 1905(a)(ii) Medically needy families and children. §§1902(a)(10)(C)(i)(III), 1905(a)(i) and 1905(a)(ii).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MINNESOTA
MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER §1902(r)(2) OF THE ACT

POLICY	HOW POLICY IS MORE LIBERAL	GROUPS TO WHICH POLICY IS APPLIED
Settlements. Exclude court-ordered settlements up to $10,000.	AFDC has no similar property exclusion.	Optional categorically needy: §§1902(a)(10)(A)(ii)(I), 1905(a)(i) and 1905(a)(ii). §§1902(a)(10)(A)(ii)(IV) and 1905(a)(ii) Medically needy families and children: §§1902(a)(10)(C)(i)(III), 1905(a)(i) and 1905(a)(ii).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MINNESOTA

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER §1902(r)(2) OF THE ACT

POLICY	HOW POLICY IS MORE LIBERAL	GROUPS TO WHICH POLICY IS APPLIED
Asset Reduction. Allow reduction of excess assets to achieve eligibility in the month of application by (i) paying incurred health service expenses for services otherwise covered by Medicaid and/or (ii) reducing excess assets in any manner not considered an uncompensated transfer subject to penalty as defined in state and federal Medicaid law. Allow reduction of excess assets to achieve eligibility in any retroactive month by (i) designating a $1500 burial fund for oneself, a spouse and each eligible dependent child and/or (ii) paying for health service costs incurred during the retroactive period.	SSI has no similar policy	Mandatory categorically needy groups including all aged, blind and disabled groups for which the state uses more restrictive policy under 1902(f), §§1902(a)(10(A)(i)(III), (IV), (VI) and (VII) and 1902(a)(10)(E). All optional categorically needy groups: §1902(a)(10)(A)(ii). Medically needy groups: §1902(a)(10)(C)(i)(III).
Burial Fund. Allow individuals who are permitted to designate asset(s) for a $1500 burial fund to make or change that designation within 3 months of the month of application.	SSI has no similar policy	Mandatory categorically needy groups including all aged, blind and disabled groups for which the state uses more restrictive policy under 1902(f), §§1902(a)(10)(A)(i)(III), (IV), (VI) and (VII) and 1902(a)(10)(E). All optional categorically needy groups: §1902(a)(10)(A)(ii). Medically needy groups: §1902(a)(10)(C)(i)(III).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MINNESOTA
MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER §1902(r)(2) OF THE ACT

POLICY	HOW POLICY IS MORE LIBERAL	GROUPS TO WHICH POLICY IS APPLIED
Disregard of Catastrophe Relief Funds. Disregard payments from the Minnesota I-35 Catastrophe Relief Funds	AFDC and SSI have no similar disregard.	Eligibility Groups under the following sections of the Act: 1902(a)(10)(A)(i)(III) ~~1902(a)(10)(A)(i)(IV)~~ ~~1902 (a)(10)(A)(i)(VI)~~ ~~1902(a)(10)(A)(i) (VII)~~ 1902(f) 1902(a)(10)(A)(ii) (I) 1902(a)(10(A)(ii) (IV) 1902(a)(10)(A)(ii)(V) 1902(a)(10)(A)(ii) (VIII) 1902(a)(10)(A)(ii) (IX) 1902(a)(10)(A)(ii) (X) 1902(a)(10)(A)(ii) (XI) 1902(a)(10)(A)(ii) (XIV) 1902(a)(10)(A)(ii) (XV) QMB, SLMB & QI under 1902(a)(10)(E) and 1905(p) Medically needy groups under §1902(a)(10)(C) (i)(III)
Disregard assets: Disregard all assets	AFDC had no such policy.	1902(a)(10)(A)(i)(III), 1905(a)(viii) 1902(a)(10)(A)(ii)(I) and (IV), 1905(a)(viii) 1902(a)(10)(C)(i)(III), 1905(a)(viii)
Disregard of burial items: Disregard burial funds, burial spaces, and burial space items excluded by SSI under 20 CFR section 416.1231as described on page 4a of Supplement 8b.	AFDC excluded one burial plot and equity in one burial agreement of up to $1500 for each member of the assistance unit.	Eligibility under the following sections of the Act: 1902(a)(10)(A)(ii) (I), 1905(a)(ii) 1902(a)(10)(A)(ii) (IV), 1905(a)(ii) 1902(a)(10)(C)(i)(III), 1905(a) (ii).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MINNESOTA
MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER §1902(r)(2) OF THE ACT

POLICY	HOW POLICY IS MORE LIBERAL	GROUPS TO WHICH POLICY IS APPLIED
Disregard under Court Order: Disregard payments to class members under the federal court order in Jensen *et al* v. Minnesota Department of Human Services, CN 09-1775 (DWF/FLM).	AFDC and SSI have no similar disregard.	Eligibility Groups under the following sections of the Act: 1902(a)(10)(A)(i)(III) 1902(f) 1902(a)(10)(A)(ii) (I) 1902(a)(10(A)(ii) (IV) 1902(a)(10)(A)(ii)(V) 1902(a)(10)(A)(ii) (VIII) 1902(a)(10)(A)(ii) (IX) 1902(a)(10)(A)(ii) (X) 1902(a)(10)(A)(ii) (XI) 1902(a)(10)(A)(ii) (XIV) 1902(a)(10)(A)(ii) (XV) QMB, SLMB & QI under 1902(a)(10)(E) and 1905(p) Medically needy groups under §1902(a)(10)(C).
Disregard of payments under NIH study: Disregard as assets any payments made to parents participating in the "income and child development in the first three years of life" demonstration project funded by the United States Department of Health and Human Services National Institutes of Health.	AFDC and SSI have no similar disregard	Eligibility Groups under the following sections of the Act: 1902(f) 1902(a)(10)(A)(ii) (I) 1902(a)(10(A)(ii) (IV) 1902(a)(10)(A)(ii)(VI) 1902(a)(10)(A)(ii) (X) 1902(a)(10)(A)(ii) (XI) 1902(a)(10)(A)(ii) (XIII) QMB, SLMB & QI under 1902(a)(10)(E) and 1905(p) Medically needy groups under §1902(a)(10)(C).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MINNESOTA

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER 1902(r)(2) OF THE ACT

Disregard of Employment Incentive Assets Account (EIAA)

Disregard of Employment Incentives Asset Account (EIAA). Disabled individuals eligible under section 1902(a)(10)(A)(XIII) will, after 24 months of consecutive enrollment under such section, qualify to establish one or more Employment Incentives Asset Accounts (EIAA). Assets that may be designated as an EIAA include assets such as a savings account, investments, mutual funds, retirement and pension accounts, and medical expense accounts. An EIAA may contain the individual's retirement accounts and medical expense benefits through an employer. An EIAA may contain up to $17,000 of the individual's other non-excluded liquid assets.

An asset disregard will apply, under the following terms:

1) The individual shall identify to the state the account(s) that he or she designates as his or her Employment Incentives Assets Account(s) before disenrollment from the group.
2) The value of the assets in the EIAA are disregarded, including growth or appreciation, except that any amount by which the value of the other liquid assets exceeds $17,000 in an EIAA is not disregarded.
3) Once the assets are designated as an EIAA they are only disregarded when the individual is enrolled in another group for individuals age 65 and older to which the EIAA disregard is applied.
4) If a person's Medicaid eligibility ends at any point before turning age 65, the EIAA will cease to exist.

Group to which disregard is applied: Individuals age 65 and older eligible under §1902(f), 1902(a)(10)(A)(ii)(I), 1902(a)(10)(A)(ii)(V), 1902(a)(10(A)(ii)(VI), 1902(a)(10)(A)(ii) (X), 1902(a)(10)(A)(ii) (XI); medically needy individuals age 65 and older eligible under §1902(a)(10)(C).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MINNESOTA

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER §1902(r)(2) OF THE ACT

1902(r)(2)
1917(b)(1)(C)

The following more liberal methodology applies to individuals who are eligible for medical assistance under one of the following eligibility groups:

- Mandatory categorically needy, including aged, blind or disabled groups for which the state uses more restrictive policy under 1902(f); §1902(a)(10)(A)(i)(III), (IV), (VI) and (VII).
- The following optional categorically needy groups:
  §1902(a)(10)(A)(ii)(I)
  1902(a)(10(A)(ii) (IV)
  1902(a)(10)(A)(ii)(V)
  1902(a)(10)(A)(ii) (VIII)
  1902(a)(10)(A)(ii) (IX)
  1902(a)(10)(A)(ii) (X)
  1902(a)(10)(A)(ii) (XI)
  1902(a)(10)(A)(ii) (XIV)
  1902(a)(10)(A)(ii) (XV)
- Medically needy groups; §1902(a)(10)(C)(i)(III).

An individual who received benefits under a long-term care insurance policy (including a certificate issued under a group insurance contract) that meets the requirements of a qualified State long-term care insurance partnership policy (partnership policy) ~~and who has exhausted the benefits of the partnership policy~~ is given, at the time of requesting or renewing Medicaid payment of long-term care services, a disregard up to the amount of the insurance benefit paid to or on behalf of the individual as described in this amendment:

- Disregard during the person's lifetime the value of assets the person designates for protection from recovery in an amount not to exceed the dollar amount of long-term care benefits utilized under a partnership policy;

- Disregard appreciation of or the protected asset's increase in value (including an increase in value due to income, dividends or profits) for a partnership participant to the extent the increase does not cause the amount of the person's total disregard to exceed the dollar value of benefits utilized under a partnership policy;

- Disregard additional assets that become available to a partnership participant with an unused amount of asset protection ~~at the time of qualifying for the partnership~~, up to the dollar amount of long-term care benefits utilized under a partnership policy; and

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MINNESOTA

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER §1902(r)(2) OF THE ACT

- Exclude from assets that may be disregarded the assets in a trust under §1917(d)(4)(A) and (C) or annuities and similar legal instruments under §1917(e).

X

The State Medicaid Agency (agency) stipulates that the following requirements will be satisfied in approving a long-term care policy for qualification of the disregard. Where appropriate, the agency relies on attestations by the commissioner of the Department of Commerce charged with regulation and oversight of insurance policies sold in the state, regarding information within the expertise of the Department of Commerce.

- The policy is a qualified long-term care insurance policy as defined in §7702(B)(b) of the Internal Revenue Code of 1986.
- The policy meets the requirements of the long-term care insurance model regulation and long-term care insurance model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) as those requirements are set forth in section 1917(b)(5) of the Social Security Act.
- The policy, if issued in this State, was issued no earlier than the effective date of this State plan amendment.
- The insured individual was a resident of this State on the date the policy was issued and first became effective. If the policy is later exchanged for a different long-term care policy, the individual was a resident of this State on the date the first policy was issued and became effective.
- The policy meets the inflation protection requirements set forth in section 1917(b)(1)(C)(iii)(IV) of the Social Security Act.
- The commissioner requires the issuer of the policy to make regular reports to the Secretary that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.
- The State does not impose any requirement affecting the terms or benefits of a partnership policy that the state does not also impose on non-partnership

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MINNESOTA

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER §1902(r)(2) OF THE ACT

policies.

- The Department of Commerce assures the agency that any individual who sells a partnership policy receives training, and demonstrates evidence of an understanding of such policies and how they relate to other forms of public and private coverage of long-term care.

- The agency provides information and technical assistance to the Department of Commerce on the training described above.

Transfer of Assets

A. For uncompensated transfers occurring on or after February 8, 2006 the agency denies Medicaid payment of long-term care services:

1. Look-back period for transfers. An applicant is denied or a recipient terminated from coverage of Medicaid long-term care services if the person or the person's spouse, or any person or entity legally authorized to act on behalf of either one, at any time during the designated look-back period immediately prior to the date the individual requests Medicaid payment of long-term care services, or at any time during the individual's receipt of Medicaid long-term care services, disposes of assets on or after February 8, 2006 for less than fair market value.

The designated look-back period is 60 months. This period will be phased in so that in February 2011 the look-back period for individuals requesting coverage of long-term care services will be a full 60 months.

Long-term care services have the meaning given them in item B below.

Allowable transfers have the meaning given them in item B below.

2. Penalty period start date. The penalty period for uncompensated transfers made on or after February 8, 2006 begins (a) for uncompensated transfers by or on behalf of individuals receiving Medicaid payment for long-term care services, the first day of the month following advance notice of the penalty period, but no later than the first day of the month that follows three full calendar months from the date of the report or discovery of the transfer; or (b) for uncompensated transfers by individuals requesting Medicaid payment of long-term care services the date on which the person is eligible for medical assistance under the State plan and would receive institutional level long-term care services but for the imposition of the penalty period; and (c) cannot begin during the running of any other period of ineligibility for uncompensated transfers.

3. Calculation of the penalty period. In determining the penalty period for an individual who has requested Medicaid payment of long-term care services, the agency uses the statewide average Medicaid rate for nursing facilities in effect at the time of filing a request for Medicaid payment of long-term care services. The statewide average figure is updated annually on July 1.

4. Transfer amounts of less than the monthly cost of nursing facility care. When the amount of an uncompensated transfer or the amount in the last month of a penalty period is less than the amount of the statewide average Medicaid rate for nursing facilities, the agency imposes a penalty for less than a full month.

The agency aggregates all uncompensated transfer amounts that are less than the statewide average Medicaid rate for nursing facilities, and calculates a single penalty period.

5. **Penalty period when both spouses request long-term care services.** The agency applies the penalty period to both spouses as described in item B below.

6. **Procedures for a waiver for undue hardship.** Individuals assessed a penalty period for uncompensated transfers are notified of the right to request a waiver for undue hardship in the notice of the penalty period. The county agency makes a decision within 30 days of the request if all necessary information has been provided, and grants an extension if more time is needed to provide information. The county agency sends the individual and the individual's representative a written notice of decision on the request for an undue hardship waiver that also advises the client of appeal rights under the fair hearing process of 42 CFR §431.200~~435.210~~ *et seq.*

The agency applies the criteria for undue hardship in item B below.

7. **Bed hold waivers.** The agency does not provide for payments to the nursing facility to hold the bed for an individual requesting a waiver of the penalty period based on undue hardship.

8. **Non-institutionalized.** The agency does not apply these provisions to non-institutionalized individuals within the meaning of §1917(c)(1)(C)(ii).

9. **Uncompensated transfers.** The following are treated as assets disposed of for less than fair market value for purposes of a request for Medicaid payment of long-term care services:

(a) A purchase of or transaction on an annuity that is an interest of the person or the person's spouse unless the state is named a preferred remainder beneficiary.
(b) The purchase of or transaction on an annuity interest in which the person requesting or receiving Medicaid payment of long-term care services is the annuitant, unless the annuity meets the criteria in §1917(c)(1)(G), and if required, the state is named a preferred remainder beneficiary.
(c) The purchase on or after July 1, 2006 of a note, loan or mortgage, unless the repayment term is actuarially sound, the repayment agreement provides for monthly payments in equal amounts of principal and interest with no deferral and no balloon payment and that prohibits cancellation upon the death of the lender.
(d) The purchase on or after July 1, 2006 of a life estate interest in the home of another unless the purchaser resides in the home for a continuous period of one year from the date of purchase.

10. **Eliminating a Penalty Period Established on or after January 1, 2011**: A penalty period cannot be shortened by a partial return of assets used in the calculation of the penalty period. A penalty period can be eliminated only if the transferors have all assets that were included in the calculation of the penalty period returned to them. An asset will not be considered returned unless the value of the asset at the time of return is no less than the asset's value on the date of the transfer. A transferee, or joint transferees, of an asset received in a form other than cash may return the value of the asset in cash if the return is made in an amount equal to the value of the asset on the date of the transfer.

B. For uncompensated transfers occurring on or after August 11, 1993:

Ineligibility for long term care services. A period of ineligibility for Medicaid payment for long term care services is provided for any institutionalized individual (including an individual receiving home and community based services under §1915(c) of the Act) who, or whose spouse or any person or entity legally authorized to act on behalf of either of them, at any time during or after the designated look-back period immediately prior to the date the individual is both an institutionalized individual and has applied for or is receiving Medicaid, disposeds of assets for less than fair market value, unless those assets were disposed of in one of the following manners:

Allowable Transfers.

- The client or the client's spouse transfers excluded assets other than a homestead or other real property.
- The client or the client's spouse transfers non-excluded assets or a homestead and provides convincing evidence of intent to receive fair market value.
- The client or the client's spouse transfers non-excluded assets or a homestead and provides convincing evidence to show the purpose of the transfer was not to obtain or maintain Medicaid. Preservation of the estate for heirs is not acceptable as "another purpose". Convincing evidence would have to show that the individual or spouse had no reason to believe that Medicaid might be needed. The sudden loss of income or assets, the sudden onset of a disabling condition or personal injury may provide convincing evidence.
- If the client entered long term care prior to October 1, 1989, the client transferred assets to a spouse in accordance with the inter-spousal transfer policies applicable to transfers occurring prior to July 1, 1988; or if the client entered long term care on or after October 1, 1989, the client transferred assets to a spouse as specified in § 1924 of the Act.
- The client or the client's spouse transferred assets to a representative of the spouse, provided the transferred assets are to be used for the sole benefit of the client's spouse.

- The client or the client's spouse transferred non-excluded assets or a homestead to his or her child of any age who is blind or permanently and totally disabled.
- The client transferred a homestead to a spouse.
- The client or the client's spouse transferred a homestead to his or her:

  (a) Child under age 21.
  (b) Child of any age who lived in the home for at least 2 years before the client entered the long term care facility and who provided verifiable care (physician's statement of needed care) that helped the client remain at home rather than in a facility.
  (c) Sibling who has equity interest in the home and who lived in the home at least 1 year immediately before the client entered the long term care facility.

  When the transfer of a homestead is exempt from penalty, it may be transferred while occupied or while vacant. It does not have to be the primary residence of the person receiving the transferred homestead.

- The client or the client's spouse transfers assets into a trust established solely for a son or a daughter of any age who is blind or disabled.
- The client or the client's spouse transfers assets into a trust established solely for any disabled person under age 65.

Long term care services defined. The term "long term care services" means nursing facility services (including those provided in a swing-bed of an inpatient hospital), ICF/MR services, and §1915(c) home and community based services.

Designated look-back period. The look-back period for transfers is 36 months, except for transfers into and from trusts which cannot be paid to or for the benefit of the Individual under any circumstances, for which the look-back period is 60 months.

Period of ineligibility. The period of ineligibility for long term care services is calculated by dividing the total uncompensated transfer amount by the statewide average monthly Medicaid rate for nursing facility (NF) services in effect on the date of filing a request for Medicaid payment of long-term care services. The average NF rate is adjusted annually on July 1 to reflect the payment rate for the previous calendar year. The period of ineligibility begins the month following the month in which the transfer occurred if no other transfers are made during the running of that penalty period. When transfers made in one or more months would result in overlapping penalty periods if the transfers were calculated separately, or if the uncompensated transfers in amounts less than the average NF rate are made during such overlapping penalty periods, the values of

all the uncompensated assets transferred are added together and an ineligibility period is recalculated. The period of ineligibility then begins in the month following the month in which the first transfer occurred.

If an uncompensated transfer made prior to August 11, 1993 results in an ineligibility period that would overlap with an ineligibility period calculated on an uncompensated transfer made on or after August 11, 1993, the ineligibility period for the transfer made on or after August 11, 1993 begins after the first ineligibility period expires.

For uncompensated transfers occurring on or after January 1, 1994 through April 13, 1996: A period of ineligibility, including partial months, shall be based on the total uncompensated value of the assets transferred divided by the average Medicaid rate for nursing facility services in the State in effect on the date of filing a request for Medicaid payment of long-term care services. However, the ineligibility provisions described in this section shall not apply to uncompensated transfers made in a month, not included in an existing period of ineligibility, totaling $1000 or less if the total value of uncompensated transfers in a month does not exceed $1000.

For uncompensated transfers occurring on or after April 13, 1996: The ineligibility provisions described in this section shall not apply to uncompensated transfers made in a month, not included in an existing period of ineligibility, totaling $500 or less if the total value of uncompensated transfers in a month does not exceed $500.

For uncompensated transfers occurring on or after July 1, 2002: The ineligibility provisions described in this section shall not apply to uncompensated transfers made in a month, not included in an existing period of ineligibility, totaling $200 or less if the total value of uncompensated transfers in a month does not exceed $200.

Ineligibility for community spouse transfers. A period of ineligibility will also be calculated if a community spouse transfers assets without receiving adequate compensation. The period of ineligibility is applied to the institutionalized spouse unless the community spouse is also receiving Medicaid payment for long term care services, in which case the penalty is applied only to the spouse who transferred the assets.

Penalty period when both spouses request long-term care services. When both spouses are eligible for Medicaid long-term care services the agency apportions an existing penalty period between them using the method outlined below:

When both spouses apply at the same time for Medicaid payment of long-term care, the penalty period is divided equally between them. If the community spouse applies for

Medicaid payment of long-term care services during the running of a penalty period for the institutionalized spouse, the remaining penalty period is divided equally between them from the date the community spouse is eligible.

If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the spouse receiving Medicaid payment of long-term care services.

Undue hardship waivers. The penalty of restricted coverage may be waived on the basis of undue hardship due to denial of medical assistance eligibility. Undue hardship must be based on an imminent threat to the client's health and well being because no other care of the person is available.

C. For transfers occurring prior to July 1, 1988:

For uncompensated transfers of non-exempt assets occurring within 24 months preceding application or while receiving Medical Assistance, a period of ineligibility for Medical Assistance shall result. The period of ineligibility is determined by dividing the uncompensated transfer amount by the statewide average payment for skilled nursing facility services for the previous calendar year.

The result, after truncating, is the number of months of ineligibility beginning with the latter of the month of transfer or the month the transfer becomes known to the agency. The value of any transferred property is added to other assets to determine if the individual is within the MA asset limit.

No individual is ineligible as determined above if:

- A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual can reasonably be expected to be discharged from the medical institution and return to the home which was transferred for less than fair market value;

- Title to the home was transferred to the individual's spouse or child who is under age 21, or is blind or permanently and totally disabled.

- A satisfactory showing is made to the agency that the individual intended to dispose of the home either at fair market value or for other value consideration; or
- The agency determines that denial of eligibility due to transfer of the homestead would work an undue hardship.

- At the time of the initial approved application, the transfer was made by an institutionalized spouse to his or her non-institutionalized spouse if all of the following conditions are met:

(1) The non-institutionalized spouse is not a Medical Assistance applicant or recipient.

(2) Either (a) the non-institutionalized spouse has less than $10,000 in countable assets, including all assets owned singly and 50 percent of assets owned jointly by both spouse; or (b) the non-institutionalized spouse has less than 60 percent of the total value of nonexempt assets owned by both spouses.

The amount transferred, together with the amount of assets described in item 2 above, total not more than one-half of the total value of the liquid assets of the parties or $10,000, whichever if greater.

(3) The non-institutionalized spouse has verified the value of his/her assets.

(4) The transfer occurs between the first of the month before the month of application and 15 days after the local agency notified the applicant of the need to reduce excess assets to gain eligibility, or the date of the local agency decision on the application, whichever is later. Transfers occurring outside of these time limits do not qualify for this exclusion.

D. For uncompensated transfers occurring since July 1, 1988:

A period of ineligibility for Medicaid payment for long term care services (including nursing facility services provided in a swingbed, institution for mental diseases, ICF/MR, Christian Science sanitoria, on an Indian reservation, or home and community based waiver services) is provided for any institutionalized individual (this includes an individual receiving home and community based services under §1915(c) of the Act) who, at any time during or after the 30-month period immediately before:

- the date the individual becomes an institutionalized individual (if the individual is entitled to Medicaid on the date of institutionalization); or

- the date the individual applies for such assistance while an institutionalized individual (if the individual was not entitled to Medicaid on the date of institutionalization), disposed of assets for less than fair market value; unless those assets were disposed of in one of the following manners:
- The client or the client's spouse transfers excluded assets other than a homestead or other real property.
- The client or the client's spouse transfers non-excluded assets or a homestead and provides convincing evidence of intent to receive fair market value.
- The client or the client's spouse transfers non-excluded assets or a homestead and

provides convincing evidence to show the purpose of the transfer was not to obtain or maintain payment of long term care services for the client. Preservation of the estate for heirs is not acceptable as "another purpose". Convincing evidence would have to show that the individual had no reason to believe that long term care services might be needed. The sudden loss of income or assets, the sudden onset of a disabling condition or personal injury may provide convincing evidence.

- If the client entered long term care prior to October 1, 1989, the client transferred assets to a spouse in accordance with the inter-spousal transfer policies applicable to transfers occurring prior to July 1, 1988; or if the client entered long term care on or after October 1, 1989, the client transferred assets to a spouse as specified in § 1924 of the Act.
- The client or the client's spouse transferred assets to a representative of the spouse, provided the transferred assets are to be used for the sole benefit of the client's spouse.
- The client or the client's spouse transferred non-excluded assets or a homestead to his or her child of any age who is blind or permanently and totally disabled.
- The client transferred a homestead to a spouse or the client or the client's spouse transferred a homestead to his or her:

    - Child under age 21
    - Child of any age who lived in the home for at least 2 years before the client entered the long term care facility and who provided verifiable care (physician's statement of needed care) that helped the client remain at home rather than in a facility.
    - Sibling who has equity interest in the home and who lived in the home at least 1 year immediately before the client entered the long term care facility.

When the transfer of a homestead is exempt from penalty, it may be transferred while occupied or while vacant. It does not have to be the primary residence of the person receiving the transferred homestead.

The penalty of restricted coverage may be waived on the basis of undue hardship due to denial of medical assistance eligibility. Undue hardship must be based on an imminent threat to the client's health and well being because no other care of the person is available.

The period of ineligibility for long term care services is calculated by dividing the total uncompensated transfer amount by the statewide average Medicaid rate for skilled nursing facility (SNF) services (nursing facility services effective October 1, 1990) in effect on the date of filing a request for Medicaid payment of long-term care services or the date the transfer becomes known to the local agency. The average rate is adjusted annually on July 1, to reflect the payment rate for the previous calendar year. The period

of ineligibility begins the month the transfer occurred. The period of ineligibility cannot exceed 30 months. If the uncompensated transfer is less than the SNF rate, eligibility for long-term care services is not affected.

If the applicant or the applicant's authorized representative, at the time of filing a request for Medicaid payment of long-term care services, failed to report a transfer of assets and the local agency is reasonably certain that the applicant or the applicant's authorized representative was aware of the transfer of assets, a cause of action exists against the person who received the transferred property if medical assistance for long term care services was received during the period of ineligibility. The Medicaid agency shall collect the lesser of:

(1) the cost of medical assistance paid for long term care services during the penalty period; or

(2) the uncompensated value of transferred property.

E. For uncompensated transfers occurring since July 1, 1990:

A period of ineligibility will also be calculated if a community spouse transfers assets without receiving adequate compensation. The period of ineligibility is applied to the institutionalized spouse unless the community spouse is also receiving long term care services, in which case the penalty is applied only to the spouse who transferred the assets.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

CONSIDERATION OF MEDICAID QUALIFYING TRUSTS--UNDUE HARDSHIP

1902(k)(4) of the Act, P.L. 99-272 (Section 9506)

Medicaid Qualifying Trusts -- Undue Hardship. The following criteria will be used to determine whether the agency will not count the funds in a trust as specified in ATTACHMENT 2.6-A, section C.2., because it would work an undue hardship for categorically and medically needy individuals:

Application of the Medicaid qualifying trust provision is waived with respect to trusts or similar legal devices created on or after July 1, 1992 and before August 11, 1993, that were established in full with awards made by the Social Security Administration pursuant to the United States Supreme Court decision in Sullivan v. Zebley, 110 S.Ct. 885 (1990).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Minnesota

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

For individuals with greater need, the following allowances are provided:

(I) 5% of gross monthly income to a maximum of $100 for reimbursement of guardianship or conservatorship services.

(ii) for disabled individuals receiving employment wages under an individual plan of rehabilitation, the following are deducted from gross earned income:

(a) $80 special personal allowance
(b) Actual FICA withheld
(c) Actual transportation expenses
(d) Actual employment expenses such as tools and uniforms
(e) Actual state and federal taxes withheld (only when the person is not exempt from withholding)

(iii) Income garnished for child support under a court order, up to a maximum of $250 per month but only to the extent that the amount garnished is not deducted as a monthly allowance for children under Item B(4)(a), on page 5 of Attachment 2.6-A.

(iv) Income garnished for spousal maintenance under a judgment and decree for dissolution of marriage, and any administrative fees garnished for collection efforts.

In addition to the basic personal needs allowance, the personal needs allowance is increased by the amount of the payment made to a class member under the federal court order *Jensen et al. v. Minnesota DHS,* to comply with the court order that the settlement amount will not affect in any way Class members eligibility for disability, benefits or otherwise jeopardize the Class members' benefits or programming.

Disclosure statement for Post-Eligibility Preprint

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is #0938-0673. The time required to complete this information collection is estimated at 5 hours per response, including the time to review instructions, searching existing data resources, gathering the data needed and completing and reviewing the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

~~The State covers low-income families and children under section 1931 of the Act.~~

~~The following groups were included in the AFDC State Plan effective July 16, 1996:~~

~~X Pregnant women with no other eligible children.~~

~~X AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.~~

~~In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996 without modification.~~

X In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996, with the following modifications.

~~The agency applies lower income standards which are no lower than the AFDC standards in effect on May 1, 1988, as follows:~~

~~The agency applies higher income standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:~~

~~Effective July 1, 2000, a one-time 3 percent increase is applied. The increased income levels for §1931 are specified on page 1 of Supplement 1 to Attachment 2.6-A.~~

~~X The agency applies higher resource standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows: The resource standard in effect is the July 16, 1996 AFDC State plan, subject to the more liberal methods.~~

~~X~~ The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:

More Liberal Income Policy 1931	**Replaces AFDC Policy of July 16, 1996**
~~For purposes of the gross income test, all income in excess of 185% will be disregarded.~~	~~AFDC applied gross income test of 185%.~~
~~A lump sum payment will be considered income in the month received and an asset thereafter.~~	~~AFDC counted lump sum payments as prospective income based on the AFDC cash grant.~~
~~The difference between the July 16, 1996 AFDC income standard and 100 percent of the current FPL, plus the cost of child (or incapacitated adult) care necessary for employment, plus the amount of any payments of court ordered child support, plus 17 percent of earned income for the first four months in which earnings are counted is disregarded; or the AFDC disregards in effect on July 16, 1996, whichever is to the family's advantage.~~	~~AFDC had no such disregard.~~
~~The agency disregards the difference between the 1931 income standard and 100 percent of the Federal poverty levels, adjusted annually on July 1st to reflect the levels previously published in the Federal Register for the year.~~	~~AFDC had no such disregard.~~
~~The agency disregards 17 percent of earned income for four months for applicants and recipients.~~	~~AFDC allowed a deduction for four months of 30% from earned income.~~
~~The agency excludes court-ordered settlements up to $10,000~~	~~AFDC had no such exclusion.~~
~~The agency disregards all payments received from the Minnesota I-35 Catastrophe Relief Fund from income.~~	~~AFDC had no such disregard.~~
~~The agency disregards up to $2000 annually in cash gifts received from tax-exempt organizations for the benefit of a child with a life-threatening illness.~~	~~AFDC had no such disregard.~~
~~The agency excludes payments to class members under the federal court order in Jensen *et al* v. Minnesota Department of Human Services, CN-09-1775 (DWF/FLN).~~	~~AFDC had no such exclusion.~~

1931 More Liberal Resource Policy	Replaces AFDC Policy of July 16, 1996
~~The agency excludes one vehicle for each person that uses a vehicle for employment or for seeking employment.~~	~~AFDC excluded equity value of up to $1500 for one vehicle per household~~
~~The agency excludes IRA's, 401(k) plans, 403(b) plans, Keogh plans and other individually-owned pension and retirement funds.~~	~~AFDC had no such exclusion.~~
~~The agency excludes court-ordered settlements up to $10,000~~	~~AFDC had no such exclusion.~~
~~The agency excludes $9,000 in property not subject to other exclusions for one person and $19,000 not subject to other exclusions for two or more people.~~	~~AFDC had no such exclusion.~~
~~The agency excludes all assets established under the Uniform Gift to Minors Act, and the child-owned portion of an account held jointly by an adult and child.~~	~~AFDC had no such exclusion.~~
~~The agency disregards all payments received from the Minnesota I-35 Catastrophe Relief Fund from resources.~~	~~AFDC had no such disregard.~~
~~The agency excludes burial funds, burial spaces and burial space items according to policy of the Supplemental Security Income (SSI) Program under 20 CFR §416.1231 as described on page 4a of Supplement 8b.~~	~~AFDC excluded one burial plot and equity in one burial agreement of up to $1500 for each member of the assistance unit.~~
~~The agency excludes payments to class members under the federal court order in Jensen *et al* v. Minnesota Department of Human Services, CN-09-1775 (DWF/FLN).~~	~~AFDC had no such exclusion.~~

____ ~~The agency terminates medical assistance (except for certain pregnant women and children) for individuals who fail to meet TANF~~ work ~~requirements.~~

__X__ ~~The agency continues to apply the following waivers of provisions of Part A of title IV in effect as of July 16, 1996, or submitted prior to August 22, 1996 and approved by the Secretary on or before July 1, 1997.~~

- ~~Waiver of §§402(a)(41) and 407 of the Act, 45 CFR 233.100(a)(1) and (c)(1)(iii). A child will be considered deprived if family income is below the applicable income standard, regardless of the number of hours that the principal wage earner is employed.~~

~~[In the 7/16/96 AFDC State plan, the principal wage earner cannot be employed over 100 hours per month.]~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

CONSIDERATION OF BLOOD PRODUCTS SETTLEMENT PAYMENTS - WAIVER

For the purpose of resolving the state's claims in the case of Susan Walker v. Bayer Corporation *et al.*, No. 6-C5024 (N.D. Ill.), the settlement payments to individual class members are not considered as income or resources in determining eligibility of or the amount of benefits for all categorically needy and medically needy groups specified in Attachment 2.2-A of the State plan, pursuant to Public Law 105-33, Title IV, subtitle H, chapter 5, section 4735.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Minnesota

ASSET VERIFICATION SYSTEM

1940(a) of the Act

1. The agency will provide for the verification of assets for purposes of determining or redetermining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an asset verification system (AVS) that meets the following minimum requirements.

A. The request and response system must be electronic:

(1) Verification inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).
(2) The system cannot be based on mailing paper-based requests.
(3) The system must have the capability to accept responses electronically.

B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department's National Institute of Standards and Technology, or NIST).

C. The system must establish and maintain a database of FIs that participate in the agency's AVS.

D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant's home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or redetermine the individual's eligibility.

E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Minnesota

ASSET VERIFICATION SYSTEM

2. System Development

___ A. The agency itself will develop an AVS.

In 3 below, provide any additional information the agency wants to include.

~~X~~ B. The agency will hire a contractor to develop an AVS.

In 3 below provide any additional information the agency wants to include.

X C. The agency will be joining a consortium to develop an AVS.

In 3 below, identify the States participating in the consortium. Also, provide any other information the agency wants to include pertaining to how the consortium will implement the AVS requirements.

___ D. The agency already has a system in place that meets the requirements for an acceptable AVS.

In 3 below, describe how the existing system meets the requirements in Section 1.

___ E. Other alternative not included in A. – D. above.

In 3 below, describe this alternative approach and how it will meet the requirements in Section 1.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Minnesota

ASSET VERIFICATION SYSTEM

3. Provide the AVS implementation information requested for the implementation approach checked in Section 2, and any other information the agency may want to include.

Participants in the New England States Consortium System Organization are Arizona, Nebraska, Rhode Island, Vermont, Minnesota.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Minnesota

DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY

1917(f) The State agency denies or terminates reimbursement for nursing facility services and other long-term care services covered under the State plan for an individual who does not have a spouse, child under 21 or adult child who is blind or permanently and totally disabled as determined by the criteria of the supplemental security income program residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

__X__ $500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

_____ An amount that exceeds $500,000 but does not exceed $750,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

The amount chosen by the State is _____.

_____ This higher standard applies statewide.

_____ This higher standard does not apply statewide. It only applies in the following areas of the State:

_____ This higher standard applies to all eligibility groups.

_____ This higher standard only applies to the following eligibility groups:

For purposes of the home equity test, a home is any real or personal property interest, including an agricultural homestead as defined under state property tax laws, owned by the person requesting Medicaid payment of long-term care services that is the primary dwelling of the individual or was the primary dwelling before receipt of long-term care services began outside the home.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Minnesota

DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY

The State has a process under which the home equity test will be waived in cases of demonstrated hardship:

A person denied or terminated from Medicaid payment of long-term care services because home equity exceeds the limit may seek a waiver based on hardship by filing a written request with the county agency. Hardship is an imminent threat to the person's health and well-being that is demonstrated by documentation of no alternatives for payment of long-term care services.

The county agency makes a decision within 30 days of the request if all necessary information has been provided, and grants an extension if more time is needed to provide information. The county agency sends the individual and the individual's representative a written notice of decision on the request for a demonstrated hardship waiver that also advises the client of appeal rights under the fair hearing process of 42 CFR §435.210 *et seq.*

State Plan Under Title XIX of the Social Security Act

State: Minnesota

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on 05/01/2014. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	**Relevant Population Group Income Standard** For each population group, indicate the lower of: • The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% FPL. If a population group was not covered as of 12/1/09, enter "Not covered".	**Resource Proxy**	**Enrollment Cap**	**Special Circumstances**	**Other Adjustments**
		Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.			
A	B	C	D	E	F
Parents/Caretaker Relatives	Attachment A, Table 1, Column G, Line 1 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No
Disabled Persons, [redacted]	Attachment A, Table 1, Column G, Line 2 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No
Disabled Persons, institutionalized	N/A	N/A	N/A	N/A	N/A
Children Age 19 or 20	Attachment A, Table 1, Column G, Line 4 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No
Childless Adults	Not covered	N/A	N/A	N/A	N/A

Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. The state:

   ☐ Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   ■ Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

   Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

   The state:

   ☐ Applies existing state data from periods before January 1, 2014.

   ☐ Applies data obtained through a post-eligibility statistically valid sample of individuals.

   Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1. ☐ An enrollment cap adjustment is applied by the state (complete items 2 through 4).

   ■ An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).

2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

3. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:

   ☐ Yes. The combined enrollment cap adjustment is described in Attachment C

   ■ No.

4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. The state:

   ☐ Applies a special circumstances adjustment(s).

   ■ Does not apply a special circumstances adjustment.

2. The state:

   ☐ Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).

   ■ Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

■ Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.

☐ The state does not have any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

The state:

☐ Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)

■ Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated 08/28/2013.

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

The state:

■ Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

☐ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated _____. The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

Part 5 - State Attestations

The State attests to the following:

A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

- ☒ Attachment A – Conversion Plan Standards Referenced in Table 1
- ☐ Attachment B – Resource Criteria Proxy Methodology
- ☐ Attachment C – Enrollment Cap Methodology
- ☐ Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- ☐ Attachment E – Transition Methodologies

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 4 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Attachment A to Supplement 18 to Attachment 2.6-A
Minnesota FMAP Claiming SPA, TN 13-36:

MOST RECENT TABLE 1 FOR PART 2
OF THE MODIFIED ADJUSTED GROSS INCOME (MAGI) CONVERSION PLAN*

*Note: The contents of this table will be updated automatically in the case of modifications in the CMS approved MAGI Conversion Plan.

Table 1

Part 2 of MAGI Conversion Plan Using State Data

	Population Group	SIPP results used? (Yes/No)	Time Period selected	Sampling (Yes/No)	Net Income Standard	Income band used in conversion*	Converted Standard
	A	B	C	D	E	F	G
Conversions for FMAP Claiming							
1	Parents/Caretaker Relatives (Expand number of rows for family size as needed for larger family size standards defined by the state) *From Part 1 of approved state MAGI conversion plan*	**No**			% FPL 275 **or** Fixed dollar standards Family size 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ Add-on for additional family members if relevant_____	% FPL _____ **or** Fixed dollar standards Family size 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ Add-on for additional family members if relevant_____	% FPL 275 **or** Fixed dollar standards Family size 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ Add-on for additional family members if relevant_____

	Population Group	SIPP results used? (Yes/No)	Time Period selected	Sampling (Yes/No)	Net Income Standard	Income band used in conversion*	Converted Standard
	A	B	C	D	E	F	G
2	Disabled adults[3]	Yes			% FPL 100 % SSI FBR _____ or Dollar Standards Single_____ Couple_____	%FPL _____ % SSI FBR _____ or Dollar Standards Single_____ Couple_____	% FPL 100 % SSI FBR _____ or Dollar Standards Single_____ Couple_____ Conversion based on: __ Average disregard __ Median disregard

[3] Medical institution services (nursing home, ICF/DD) were included in the Medicaid benefits for disabled individuals in the optional poverty level group under 1902(a)(10)(A)(ii)(X).

	Population Group	SIPP results used? (Yes/No)	Time Period selected	Sampling (Yes/No)	Net Income Standard	Income band used in conversion*	Converted Standard
	A	B	C	D	E	F	G
4	Children age 19 and/or 20 **Specify age limit as of 12/1/09** **(19 or 20): 20** *From Part 1 of approved state MAGI conversion plan*	**No**			% FPL 100 or Fixed dollar standards Family size 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ Add-on for additional family members if relevant_____	% FPL _____ or Fixed dollar standards Family size 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ Add-on for additional family members if relevant_____	% FPL 102 or Fixed dollar standards Family size 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ Add-on for additional family members if relevant_____
5	Childless Adults				% FPL n/a	% FPL _____	% FPL n/a

*Alternative method states: only fill out column F if applicable.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

AFDC Income Standards — S14

Enter the AFDC Standards below. All states must enter:

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988 and
AFDC Payment Standard in Effect As of July 16, 1996

Entry of other standards is optional.

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

Income Standard Entry - Dollar Amount - Automatic Increase Option — S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ◉ Standard varies in some other way

Enter the standard by some other way

Remove

Name: Family composition: children

Description: Household members are all children; incremental amount is for each additional child.

	Household size	Standard ($)	
+	1	297	X
+	2	407	X
+	3	512	X
+	4	604	X
+	5	697	X
+	6	789	X
+	7	871	X
+	8	952	X

+	9	1,023
+	10	1,093

Additional incremental amount

(•) Yes ( ) No

Increment amount $ 70

Remove

Name

Family composition: children with one adult

Description

Household members include one parent or relative caretaker with children; incremental amount is for each additional child

	Household size	Standard ($)
+	1	549
+	2	662
+	3	790
+	4	894
+	5	1,000
+	6	1,105
+	7	1,200
+	8	1,293
+	9	1,377
+	10	1,460

Additional incremental amount

(•) Yes ( ) No

Increment amount $ 83

Remove

Name

Family composition: children with two adults

Description

Household members include two parents or two relative caretakers with children; incremental amount is for each additional child.

	Household size	Standard ($)
+	1	625
+	2	743

+	3	856	X
+	4	955	X
+	5	1,055	X
+	6	1,155	X
+	7	1,244	X
+	8	1,332	X
+	9	1,411	X
+	10	1,489	X

Additional incremental amount

(•) Yes ( ) No

Increment amount $ 77

Add

The dollar amounts increase automatically each year

( ) Yes (•) No

AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option — S13a

The standard is as follows:

( ) Statewide standard

( ) Standard varies by region

( ) Standard varies by living arrangement

(•) Standard varies in some other way

Enter the standard by some other way

Remove

Name: Family composition: children only

Description: Household members are all children; incremental amount is for each additional child.

	Household size	Standard ($)	

1	250	X
2	345	X
3	434	X
4	510	X
5	586	X
6	663	X
7	729	X
8	793	X
9	848	X
10	902	X

Additional incremental amount

(•) Yes ( ) No

Increment amount $ 53

Remove

Name

Family composition: children with one adult

Description

Household members include one parent or relative caretaker with children; incremental amount is for each additional child

Household size	Standard ($)	
1	437	X
2	532	X
3	621	X
4	697	X
5	773	X
6	850	X
7	916	X
8	980	X
9	1,035	X

+	10	1,089 X

Additional incremental amount
◉ Yes ○ No

Increment amount $ 53

Remove

Name
Family composition: children with two adutls

Description
Household members include two parents or relative caretakers with children; incremental amount is for each additional child.

	Household size	Standard ($)	
+	1	510	X
+	2	605	X
+	3	694	X
+	4	770	X
+	5	846	X
+	6	923	X
+	7	989	X
+	8	1,053	X
+	9	1,108	X
+	10	1,162	X

Additional incremental amount
◉ Yes ○ No

Increment amount $ 53

Add

The dollar amounts increase automatically each year
○ Yes ◉ No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option — S14a

The standard is as follows:

○ Statewide standard

○ Standard varies by region

○ Standard varies by living arrangement

○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

AFDC Need Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

○ Statewide standard

○ Standard varies by region

○ Standard varies by living arrangement

○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date.

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

○ Statewide standard

○ Standard varies by region

○ Standard varies by living arrangement

○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ◯ Statewide standard
- ◯ Standard varies by region
- ◯ Standard varies by living arrangement
- ◯ Standard varies in some other way

The dollar amounts increase automatically each year

◯ Yes ◯ No

TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ◯ Statewide standard
- ◯ Standard varies by region
- ◯ Standard varies by living arrangement
- ◯ Standard varies in some other way

The dollar amounts increase automatically each year

◯ Yes ◯ No

MAGI-equivalent TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ◯ Statewide standard
- ◯ Standard varies by region
- ◯ Standard varies by living arrangement
- ◯ Standard varies in some other way

The dollar amounts increase automatically each year

◯ Yes ◯ No

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Parents and Other Caretaker Relatives **S25**

42 CFR 435.110
1902(a)(10)(A)(i)(I)
1931(b) and (d)

■ **Parents and Other Caretaker Relatives** - Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

☒ This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.

☒ Options relating to the definition of caretaker relative (select any that apply):

☐ The definition of caretaker relative includes the domestic partner of the parent or other caretaker relative, even after the partnership is terminated.

Definition of domestic partner:

☒ The definition of caretaker relative includes other relatives of the child based on blood (including those of half-blood), adoption or marriage.

Description of other relatives: Grandparents, aunts, uncles, first cousins, nephews or nieces, persons of preceding generations, (grand, great, great-great), stepparents, stepsiblings, spouses of any of these individuals.

☐ The definition of caretaker relative includes any adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

☒ Options relating to the definition of dependent child (select the one that applies):

◉ The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.

○ The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):

Medicaid Eligibility

■ Have household income at or below the standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for this group

■ Minimum income standard

The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

☑ The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

An attachment is submitted.

■ Maximum income standard

☐ The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

○ The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

◉ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

◉ A percentage of the federal poverty level: 275 %

○ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ Other dollar amount

■ Income standard chosen:

Indicate the state's income standard used for this eligibility group:

○ The minimum income standard

○ The maximum income standard

○ The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14 AFDC Income Standards.

◉ Another income standard in-between the minimum and maximum standards allowed

○ The state's AFDC payment standard in effect as of July 16, 1996, not converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ The state's TANF payment standard, not converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

◉ Other income standard in-between the minimum and the maximum standards allowed.

The amount of the income standard for this eligibility group is:

◉ A percentage of the federal poverty level: 133 %

○ A dollar amount

■ There is no resource test for this eligibility group.

■ Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

Medicaid Eligibility

○ Yes ◉ No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Pregnant Women **S28**

42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

■ **Pregnant Women** - Women who are pregnant or post-partum, with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.

◉ Yes ○ No

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for this group

■ Minimum income standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

◉ Yes ○ No

Enter the amount of the minimum income standard (no higher than 185% FPL): 185 % FPL

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

◉ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

Medicaid Eligibility

○ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 185% FPL

The amount of the maximum income standard is: 278 % FPL

■ Income standard chosen

Indicate the state's income standard used for this eligibility group:

○ The minimum income standard

◉ The maximum income standard

○ Another income standard in-between the minimum and maximum standards allowed.

■ There is no resource test for this eligibility group.

■ Benefits for individuals in this eligibility group consist of the following:

◉ All pregnant women eligible under this group receive full Medicaid coverage under this state plan.

○ Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.

■ Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage Infants and Children under Age 19 — S30

42 CFR 435.118
1902(a)(10)(A)(i)(III), (IV), (VI) and (VII)
1902(a)(10)(A)(ii)(IV) and (IX)
1931(b) and (d)

■ **Infants and Children under Age 19** - Infants and children under age 19 with household income at or below standards established by the state based on age group.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Children qualifyiug under this eligibility group must meet the following criteria:

■ Are under age 19

■ Have household income at or below the standard established by the state.

■ MAGI-based iucome methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for infants under age one

■ Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

◉ Yes ○ No

Enter the amount of the minimum income standard (no higher than 185% FPL): 185 % FPL

■ Maximum income standard

☐ The state certifies that it has submitted and received approval for its converted income standard(s) for infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.

An attachment is submitted.

The state's maximum iucome standard for this age group is:

◉ The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), I902(a)(I0)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and I902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 185% FPL

Enter the amount of the maximum income standard: 275 % FPL

■ Income standard chosen

The state's income standard used for infants under age one is:

◉ The maximum income standard

○ If not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

■ Income standard for children age one through age five, inclusive

■ Minimum income standard

The minimum income standard used for this age group is 133% FPL.

☑ Maximum income standard

☐ The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.

An attachment is submitted.

The state's maximum income standard for children age one through five is:

○ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

◉ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Enter the amount of the maximum income standard: 275 % FPL

☑ Income standard chosen

The state's income standard used for children age one through five is:

◉ The maximum income standard

○ If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

■ Income standard for children age six through age eighteen, inclusive

■ Minimum income standard

The minimum income standard used for this age group is 133% FPL.

■ Maximum income standard

☐ The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.

An attachment is submitted.

The state's maximum income standard for children age six through eighteen is:

○ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

◉ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 133% FPL

Enter the amount of the maximum income standard: 275 % FPL

■ Income standard chosen

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Adult Group **S32**

1902(a)(10)(A)(i)(VIII)
42 CFR 435.119

The state covers the Adult Group as described at 42 CFR 435.119.

(●) Yes ( ) No

[■] **Adult Group** - Non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.

[☑] The state attests that it operates this eligibility group in accordance with the following provisions:

[■] Individuals qualifying under this eligibility group must meet the following criteria:

[■] Have attained age 19 but not age 65.

[■] Are not pregnant.

[■] Are not entitled to or enrolled for Part A or B Medicare benefits.

[■] Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

Note: In 209(b) states, individuals receiving SSI or deemed to be receiving SSI who do not qualify for mandatory Medicaid eligibility due to more restrictive requirements may qualify for this eligibility group if otherwise eligible.

[■] Have household income at or below 133% FPL.

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

[■] There is no resource test for this eligibility group.

[■] Parents or other caretaker relatives living with a child under the age specified below are not covered unless the child is receiving benefits under Medicaid, CHIP or through the Exchange, or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

( ) Under age 19, or

(●) A higher age of children, if any, covered under 42 CFR 435.222 on March 23, 2010:

( ) Under age 20

(●) Under age 21

[■] Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

( ) Yes (●) No

Medicaid Eligibility

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Former Foster Care Children **S33**

42 CFR 435.150
1902(a)(10)(A)(i)(IX)

■ **Former Foster Care Children** - Individuals under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and in foster care when they turned age 18 or aged out of foster care.

☑ The state attests that it operates this eligibility group under the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Are under age 26.

■ Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

■ Were in foster care under the responsibility of the state or Tribe and were enrolled in Medicaid under the state's state plan or 1115 demonstration when they turned 18 or at the time of aging out of that state's or Tribe's foster care program.

The state elects to cover children who were in foster care and on Medicaid in any state at the time they turned 18 or aged out of the foster care system.

○ Yes ◉ No

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Individuals above 133% FPL	S50

1902(a)(10)(A)(ii)(XX)
1902(hh)
42 CFR 435.218

Individuals above 133% FPL - The state elects to cover individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.218.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Optional Coverage of Parents and Other Caretaker Relatives	S51

42 CFR 435.220
1902(a)(10)(A)(ii)(I)

Optional Coverage of Parents and Other Caretaker Relatives - The state elects to cover individuals qualifying as parents or other caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.220.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Reasonable Classification of Individuals under Age 21 S52

42 CFR 435.222
1902(a)(10)(A)(ii)(I)
1902(a)(10)(A)(ii)(IV)

Reasonable Classification of Individuals under Age 21 - The state elects to cover one or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.222.

(●) Yes ( ) No

☐ The state attests that it operates this eligibility group in accordance with the following provisions:

☑ Individuals qualifying under this eligibility group must qualify under a reasonable classification by meeting the following criteria:

☑ Be under age 21, or a lower age, as defined within the reasonable classification.

☑ Have household income at or below the standard established by the state, if the state has an income standard for the reasonable classification.

☑ Not be eligible and enrolled for mandatory coverage under the state plan.

☑ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered at least one reasonable classification under this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

(●) Yes ( ) No

The state also covered at least one reasonable classification under this group in the Medicaid state plan as of March 23, 2010 with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

(●) Yes ( ) No

Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

☐ The state attaches the approved pages from the Medicaid state plan as of March 23, 2010 to indicate the age groups, reasonable classifications, and income standards used at that time for this eligibility group.

An attachment is submitted.

Current Coverage of All Children under a Specified Age

The state covers all children under a specified age limit, equal to or higher than the age limit and/or income standard used in the Medicaid state plan as of March 23, 2010, provided the income standard is higher than the current mandatory income standard for the individual's age. The age limit and/or income standard used must be no higher than any age limit and/or income standard covered in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013. Higher income standards may include the disregard of all income.

◉ Yes ○ No

Indicate below the age under which all children are covered under this eligibility group, based on a specific age group used previously in the Medicaid state plan or under a Demonstration, which is equal to or higher than the age group for coverage of all children in the Medicaid state plan as of March 23, 2010.

◉ Under age 21 ○ Under age 20 ○ Under age 19 ○ Under age 18

Enter the income standard used for this age group. The standard must be higher than the mandatory income standard for the individual's age, not more restrictive than that used in the Medicaid state plan as of March 23, 2010 and not less restrictive than that used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

■ Income standard used

■ Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

■ Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

○ Yes ◉ No

☑ The state certifies that it has submitted and received approval for its converted income standards for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

○ The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

A percentage of the federal poverty level: 275 %

The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

The state's TANF payment standard, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

Other dollar amount

Income standard chosen

Individuals qualify under this classification under the following income standard:

The minimum standard.

The maximum income standard.

If not chosen as the maximum income standard, the state's effective income level for this classification under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

The income standard used for this classification is:

- (●) A percentage of the federal poverty level: 133 %
- ( ) The state's TANF payment standard, not converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.
- ( ) The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.
- ( ) The state's TANF payment standard, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.
- ( ) Other dollar amount

Current Coverage of Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

The state covers reasonable classifications of children previously covered in the Medicaid state plan as of March 23, 2010, with income standards higher than the current mandatory income standard for the age group. Age limits and income standards are equal to or higher than the Medicaid state plan as of March 23, 2010, but no higher than any age limit and/or income standard for this classification covered in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013. Higher income standards may include the disregard of all income.

( ) Yes (●) No

Other Reasonable Classifications Previously Covered

The state covers reasonable classifications of children not covered in the Medicaid state plan as of March 23, 2010, but covered under the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013 with an income standard higher than the current mandatory income standard for the age group.

( ) Yes (●) No

Additional new age groups or reasonable classifications covered

If the state has not elected to cover the Adult Group (42 CFR 435.119), it may elect to cover additional new age groups or reasonable classifications that have not been covered previously. If the state covers the Adult Group, this additional option is not available, as the standard for the new age groups or classifications is lower than that used for mandatory coverage.

The state does not cover the Adult Group and elects the option to include in this eligibility group additional age groups or reasonable classifications that have not been covered previously in the state plan or under a Medicaid 1115 Demonstration. Any additional age groups or reasonable classifications not previously covered are restricted to the AFDC income standard from July 16, 1996, not converted to a MAGI-equivalent standard.

( ) Yes (●) No

[■] There is no resource test for this eligibility group.

Medicaid Eligibility

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage: Children with Non IV-E Adoption Assistance

S53

42 CFR 435.227
1902(a)(10)(A)(ii)(VIII)

Children with Non IV-E Adoption Assistance - The state elects to cover children with special needs for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid, or who had income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.227.

(●) Yes ( ) No

[✓] The state attests that it operates this eligibility group in accordance with the following provisions:

[■] Individuals qualifying under this eligibility group must meet the following criteria:

[■] The state adoption agency has determined that they cannot be placed without Medicaid coverage because of special needs for medical or rehabilitative care;

[■] Are under the following age (see the Guidance for restrictions on the selection of an age):

(●) Under age 21

( ) Under age 20

( ) Under age 19

( ) Under age 18

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(●) Yes ( ) No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

(●) Yes ( ) No

[■] Individuals qualify under this eligibility group if they were eligible under the state's approved state plan prior to the execution of the adoption agreement.

The state used an iucome standard or disregarded all income for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(●) Yes ( ) No

[■] Income standard used for this eligibility group

[■] Minimum income standard

The minimum income standard for this eligibility group is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

[■] Maximum income standard

Medicaid Eligibility

No income test was used (all income was disregarded) for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

◉ Yes ○ No

☒ No income test was used (all income was disregarded) for this eligibility group under (check all that apply):

- ☒ The Medicaid state plan as of March 23, 2010.
- ☒ The Medicaid state plan as of December 31, 2013.
- ☐ A Medicaid 1115 Demonstration as of March 23, 2010.
- ☐ A Medicaid 1115 Demonstration as of December 31, 2013.

The state's maximum standard for this eligibility group is no income test (all income is disregarded).

☒ Income standard chosen

Individuals qualify under this eligibility group under the following income standard, which must be higher than the minimum for this child's age:

This eligibility group does not use an income test (all income is disregarded).

☒ There is no resource test for this eligibility group.

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Optional Targeted Low Income Children **S54**

1902(a)(10)(A)(ii)(XIV)
42 CFR 435.229 and 435.4
1905(u)(2)(B)

Optional Targeted Low Income Children - The state elects to cover uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.229.

◉ Yes ○ No

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must not be eligible for Medicaid under any mandatory eligibility group.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group in the state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

◉ Yes ○ No

The state also covered this eligibility group in the state plan as of March 23, 2010.

◉ Yes ○ No

■ Until October 1, 2019, states must include at least those individuals covered as of March 23, 2010, but may cover additional individuals. Effective October 1, 2019, states may reduce or eliminate coverage for this group.

■ Individuals are covered under this eligibility group, as follows:

○ All children under age 18 or 19 are covered:

◉ The reasonable classification of children covered is:

○ Under age 1

○ Age 1 through age 5, inclusive

○ Age 6 through age 18, inclusive

◉ Under age 2

○ Age ____ through age ____

■ Income standard used for this classification

■ Minimum income standard

The income standard for this classification of children must exceed the lowest income standard chosen for children in the age group selected above, under the mandatory Infants and Children under Age 19 eligibility group.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

◉ The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for this classification of children under the Medicaid State Plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for this classification of children under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for this classification of children under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 200% FPL.

○ A percentage of the FPL which may exceed the Medicaid Applicable Income Level, defined in section 2110(b)(4) of the Act, but by no more than 50 percentage points.

■ The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

283 % FPL

■ Income standard chosen, which must exceed the minimum income standard

Individuals qualify under the following income standard:

◉ The maximum income standard.

○ The state's effective income level for this eligibility group under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the effective income level used under the state plan as of March 23, 2010, the state's effective income level for this eligibility group under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ If higher than the effective income level used under the state plan as of March 23, 2010, the state's effective income level for this eligibility group under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the effective income level used under the state plan as of March 23, 2010, the state's effective income level for this eligibility group under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ If higher than the effective income level used under the state plan as of March 23, 2010, 200% FPL.

○ If higher than the effective income level used under the state plan as of March 23, 2010, a percentage of the FPL which may exceed the Medicaid Applicable Income Level, defined in section 2110(b)(4) of the Act, but by no more than 50 percentage points.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this eligibility group in the state plan as of March 23, 2010.

The income standard for this eligibility group is: 283 % FPL

■ There is no resource test for this eligibility group.

■ Presumptive Eligibility

■ Presumptive eligibility for this group depends upon the selection of presumptive eligibility for the Infants and Children under Age 19 eligibility group. If presumptive eligibility is done for that group, it is done for this group under the same provisions.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

State Name: Minnesota

OMB Control Number: 0938-1148

Transmittal Number: MN - 15 - 0006

Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Individuals Eligible for Family Planning Services

S59

1902(a)(10)(A)(ii)(XXI)
42 CFR 435.214

Individuals Eligible for Family Planning Services - The state elects to cover individuals who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services and in accordance with provisions described at 42 CFR 435.214.

(•) Yes ( ) No

[✓] The state attests that it operates this eligibility group in accordance with the following provisions:

[■] The individual may be a male or a female.

[■] Income standard used for this group

[■] Maximum income standard

[✓] The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is the highest of the following:

(•) The state's current effective income level for the Pregnant Women eligibility group (42 CFR 435.116) under the Medicaid state plan.

( ) The state's current effective income level for pregnant women under a Medicaid 1115 demonstration.

( ) The state's current effective income level for Targeted Low-Income Pregnant Women under the CHIP state plan.

( ) The state's current effective income level for pregnant women under a CHIP 1115 demonstration.

The amount of the maximum income standard is: 278 % FPL

[■] Income standard chosen

The state's income standard used for this eligibility group is:

( ) The maximum income standard

(•) Another income standard less than the maximum standard allowed.

The amount of the income standard is: 200 % FPL

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

Medicaid Eligibility

- [x] In determining eligibility for this group, the state uses the following household size:
  - [x] All of the members of the family are included in the household
  - [ ] Only the applicant is included in the household
  - [ ] The state increases the household size by one
- [x] In determining eligibility for this group, the state uses the following income methodology:
  - (•) The state considers the income of the applicant and all legally responsible household members (using MAGI-based methodology).
  - ( ) The state considers only the income of the applicant.
- [x] Benefits for this eligibility group are limited to family planning and related services described in the Benefit section.
- [x] Presumptive Eligibility

  The state makes family planning services and supplies available to individuals covered under this group when determined presumptively eligible by a qualified entity.

  (•) Yes ( ) No

  The state also covers medical diagnosis and treatment services that are provided in conjunction with a family planning service in a family planning setting during the presumptive eligibility period.

  (•) Yes ( ) No

  - [x] The presumptive period begins on the date the determination is made.
  - [x] The end date of the presumptive period is the earlier of:

    The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

    The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

  - [x] Periods of presumptive eligibility are limited as follows:
    - ( ) No more than one period within a calendar year.
    - ( ) No more than one period within two calendar years.
    - (•) No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.
    - ( ) Other reasonable limitation:

Medicaid Eligibility

The state requires that a written application be signed by the applicant or representative.

(●) Yes ( ) No

[ ] The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

[●] The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

[■] The presumptive eligibility determination is based on the following factors:

[■] The individual must not be pregnant.

[■] Household income must not exceed the applicable income standard specified for this group.

[☒] State residency

[ ] Citizenship, status as a national, or satisfactory immigration status

[■] The state uses entities, as defined in section 1920C, to determine eligibility presumptively for this eligibility group. These entities must be eligible to receive payment for services under the state's approved Medicaid state plan and determined by the state to be capable of determining presumptive eligibility for this group.

The types of entities used to determine presumptive eligibility for this eligibility group are:

	Name of entity	Description	
+	Other	Enrolled Medicaid health care providers who are certified by signing an agreement and completing training and who are: family planning providers (physicians, nurse practitioners, certified nurse midwives, physician-directed clinics, community health clinics, rural health clinics, outpatient hospital departments, pharmacies, public health clinics, and family planning agencies); or clinical nurse specialists, laboratories, ambulatory surgical centers, federally qualified health centers, Indian health services, public health nursing clinics, or physician assistants.	X

[☑] The state assures that it has communicated the requirements for entities, at 1920C of the Act, and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

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V.20140415

INDIVIDUALS ELIGIBLE FOR FAMILY PLANNING SERVICES (Attachment to S59)	
TRANSMITTAL NUMBER: **15-006**	**STATE:** **Minnesota**
In addition to coverage of individuals age 21 and older described in 1902(ii) with the elections in S59, the state also covers a categorical population listed under section 1902(a)(10)(A)(ii)(XXI) of the Social Security Act: individuals described in clause (i) of 1905(a) who are individuals under age 21 and who are described in section 1902(ii). The elections in S59 for income limit, household size, and benefits apply to this population, but in determining eligibility for this reasonable classification of children the state applies the election under 1902(ii)(3) and considers only the income of the applicant or recipient.	

SUPERSEDING & OBSOLETE PAGES OF STATE PLAN MATERIAL		
TRANSMITTAL NUMBER: MN-130027-MM1	**STATE:** Minnesota	

Pages or sections of pages being superseded by S25, S28, S30, S51, S52, S53, S54, and S14 and related pages or sections of pages being deleted as obsolete by CMS

State Plan Section	Complete Pages Superseded	Partial Pages Superseded	Preprint deemed obsolete by CMS
Attachment 2.2-A	Page 1 Page 3 Page 3a Page 4 Page 4a Page 12, TN 91-26 Page 13,TN 09-001 Page 14 Page 21 Page 23b	Page 2, under item A.2 remove b and c Page 2a, under item A, remove number 3 Page 5, under item A, remove number 10 Page 9c, under item B.1, remove "Caretaker relatives" and "Pregnant women." Page 13a, except number 7(b)6 is retained.	Page 14a Page 23 Page 20, B.14 Page 25, C.4
Attachment 2.6-A	Page 1, A.2.a(i) and (iii) Page 11a Page 19 Page 19a Page 19b Page 21	Page 1, A.2.a(i) and (iii) Page 6, related to AFDC recipients, pregnant women, infants, and children, except to the extent relevant to the AFDC-related medically needy group.	Page 3b Page 25, 11.a(3)

		Page 7, 1.a(1) and (2) Page 12, 5.e(2) Page 18, 5.e	
Supplement 1 to Attachment 2.6-A	Pages 1-4 of 7		
Supplement 2 to Attachment 2.6-A	Pages 1-5 of 7		
Supplement 8a to Attachment 2.6-A	Page 3	Page 2, delete 1st disregard for pregnant women & infants and 3rd disregard for AFDC-related groups Page 5, delete all disregards except those for medically needy Page 6, delete all disregards for AFDC-related categorically needy groups	
Supplement 8b to Attachment 2.6-A		Pages 1, 2 & 5, delete all disregards for AFDC-related categorically needy groups	
Supplement 13 to Attachment 2.6-A	Pages 1-3		
Supplement 14 to Attachment 2.6-A			Page 1

State: MINNESOTA

Agency*	Citation	Groups Covered

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups

42 CFR 435.110

~~1. Recipients of AFDC~~

The approved State AFDC plan includes:

___ Families with an unemployed parent for the mandatory 6 month period and an optional extension of ___ months.

~~X Families with an unemployed parent.~~

~~X Pregnant women with no other eligible children.~~

~~X AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.~~

The standards for AFDC payments are listed in Supplement 1 of Attachment 2.6-A.

42 CFR 435.115

~~2. Deemed Recipients of AFDC~~

~~a. Individuals denied a title IV-A cash payment solely because the amount would be less than $10.~~

*Agency that determines eligibility for coverage.

State: MINNESOTA

Agency*	Citation	Groups Covered

A. **Mandatory Coverage – Categorically Needy and other Required Special Groups (Continued)**

2. Deemed Recipients of AFDC.

1902(a)(10)(A)(i)(I) of the Act

b. ~~Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relatives of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e) of the Act.~~

402(a)(22)(A) of the Act

c. ~~Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.~~

406(h) and 1902(a)(10)(A)(i)(I) of the Act

d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.

1902(a) of the Act

e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

*Agency that determines eligibility for coverage.

State: MINNESOTA

Agency*	Citation	Groups Covered

A. Mandatory Coverage – Categorically Needy and other Required Special Groups (Continued)

407(b), 1902(a)(10)(A)(i) and 1905(m)(1)

~~3. Qualified Family Members~~

~~Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed~~.

~~/~~X~~/ Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.~~

1902(a)(52) and 1925of the Act

4. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act.

*Agency that determines eligibility for coverage.

State: MINNESOTA

Agency*	Citation	Groups Covered

A. Mandatory Coverage – Categorically Needy and other Required Special Groups (Continued)

42 CFR 435.113

~~5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are:~~

~~a. Families denied AFDC solely because of income and resources deemed to be available from –~~

~~(1) Stepparents who are not legally liable for support of stepchildren under a State law of general applicability;~~
~~(2) Grandparents;~~
~~(3) Legal guardians; and~~
~~(4) Individual alien sponsors (who are not spouses of the individuals or the individual's parent);~~

~~b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.~~

~~c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.~~

*Agency that determines eligibility for coverage.

State: MINNESOTA

Agency*	Citation	Groups Covered

A. Mandatory Coverage – Categorically Needy and other Required Special Groups (Continued)

42 CFR 435.114

~~6. Individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.~~

~~X Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).~~

~~X Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).~~

~~X Not applicable with respect to intermediate care facilities; State did or does not cover this service.~~

1902(a)(10)(A)(i)(III) and 1905(n) of the Act

~~7. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act.~~

*Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation	Groups Covered

A. **Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)**

~~7. a. (2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents program; or~~

~~(3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.~~

1902(a)(10)(A)(i)(III) and 1905(n)

~~b. Children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.~~

~~X Children who are born after September 30, 1973 (optional earlier date) and who have not attained the age of 19.~~

State: MINNESOTA

Citation	Groups Covered

A. **Mandatory Coverage – Categorically Needy and other Required Special Groups (Continued)**

1902(a)(10)(A)(i)(IV), 1902(l)(1)(A) and (B) of the Act

~~8. Pregnant women and infants under 1 year of age with family incomes up to 133 percent of the Federal poverty level who are described in section 1902(a)(10)(A)(i)(IV) and 1902(l)(1)(A) and (B) of the Act. The income level for this group is specified in supplement 1 to Attachment 2.6-A.~~

~~X The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.~~

~~9. Children:~~

1902(a)(10)(A) (i)(VI) and 1902(l)(1)(C) of the Act

~~a. who have attained 1 year but have not attained 6 years of age, with family incomes at or below 133 percent of the Federal poverty levels.~~

1902(a)(10)(A)(i)(VII) and 1902(l)(1)(D) of the Act

~~b. born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty level.~~

~~Income levels for these groups are specified in Supplement 1 to Attachment 2.5-A.~~

State: MINNESOTA

COVERAGE AND CONDITIONS OF ELIGIBILTY

Citation	Groups Covered
	A. **Mandatory Coverage – Categorically Needy and other Required Special Groups (Continued)**
1902(a)(10)(A)(i)(V), 1905(m) of the Act	~~10. Individuals other than qualified pregnant women and children under item A.7 above who are members of a family that would be receiving AFDC under section 407 of the Act of the State had not exercised the option under section 407(b)(2)(B)(2)(i) of the Act to limit the number of months for which a family may receive AFDC.~~
1902(e)(5)	11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and post-partum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy and for any remaining days in the month in which the 60th day falls.
1902(e)(6) of the Act	b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the post-partum period which extends through the end of the month in which the 60-day period (beginning on the last day of the pregnancy) ends.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Minnesota

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citations	Groups Covered
	A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
1902(e)(4) of the Act	12. Deemed Newborns. A child born to a woman who is eligible for and receiving Medicaid ~~as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother~~ (including coverage of an alien for labor and delivery as emergency medical services) for the date of the child's birth, including retroactively. The child is deemed eligible for one year from birth.
42 CFR 435.120	13. Aged, Blind and Disabled Individuals Receiving Cash Assistance ____ a. Individuals receiving SSI. This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal or excess resources under an agreement with the Social Security administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act. ____ Aged ____ Blind ____ Disabled

State: MINNESOTA

Citation	Groups Covered

A. **Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)**

435.121 13. X b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)

PL. 105-33, section 4913

The group under this section 13(b) also include children under age 18 who were receiving SSI benefits on August 22, 1996 and who, but for the passage of the disability definition in P. L. 104-193 would continue to be paid such benefits.

X Aged

X Blind

X Disabled

(Financial criteria are described in ATTACHMENT 2.6-A)

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1902(a)(10)(A)(i)(II) and 1905(q) of the Act	14. Qualified severely impaired blind and disabled individuals under age 65, who--
		a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or
		b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must--
		(1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;
		(2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;
		(3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and

(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would b available if he or she did have such earnings.

/ / Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)		Groups Covered
		A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1619(b)(3) of the Act	/X/	The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1634(c) of the Act

15. ~~Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI,~~ Blind or disabled individuals who--

a. Are at least 18 years of age;

b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.

/X/ c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

/ / d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.

42 CFR 435.122

16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.

42 CFR 435.130

17. Individuals receiving mandatory State supplements.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.131

18. Individuals who in December 1973 were eligible fo Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cas assistance. The recipient with whom the essentia spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.

/ / In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

___ Aged ___ Blind ___ Disabled

/X/ Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	42 CFR 435.132	19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they--
		a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and
		b. Remain institutionalized; and
		c. Continue to need institutional care.
	42 CFR 435.133	20. Blind and disabled individuals who--
		a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and
		b. Were eligible for Medicaid in December 1973 as blind or disabled; and
		c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.134

21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

/X/ Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

/X/ Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

/ / Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.135 22. Individuals who --

a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and

b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

/ / Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.

/ / Not applicable because the State applies more restrictive eligibility requirements than those under SSI.

/X/ The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1634 of the Act	23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.
		/_/ Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.
		/X/ The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equalling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1634(d) of the Act

24. Disabled widows and widowers who would be eligible for SSI except for receipt of early social security disability benefits, who are not entitled to hospital insurance under Medicare Part A and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries under section 1634(d) of the Act.

/_/ Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.

/_/ Not applicable because the State applies more restrictive eligibility than those under SSI and the State chooses not to deduct any of the benefit that caused SSI/SSP ineligibility or subsequent cost-of-living increases.

/X/ The State applies more restrictive eligibility requirements than those under SSI and part or all of the amount of the benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

*Agency that determines eligibility for coverage.

Citation	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (continued)
1902 (a)(10)(E)(i), 1905(p) and 1860D-14(a)(3)(D) of the Act	25. Qualified Medicare beneficiaries – a Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act); b. Whose income does not exceed 100 percent of the Federal poverty level; and c. Whose resources do not exceed ~~twice~~ three times the maximum standard under SSI, adjusted annually by the increase in the consumer price index. (Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)
1902(a)10)(E)(ii) 1905(a) and 1905(p)(3)(A)(i) of the Act	26. Qualified disabled and working individuals -- a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act; b. Who income does not exceed 200 percent of the Federal poverty level; and c. Whose resources do not exceed twice the maximum standard under SSI. d. Who are not otherwise eligible for medical assistance under Title XIX of the Act. (Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)

Citation	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (continued)
1902(a)(10)(E)(iii), 1905(p)(3)(A)(ii) and 1860D-14(a)(3)(D) of the Act	27. Specified low-income Medicare beneficiaries – a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act); b. Whose income for calendar years 1993 and 1994 exceeds the income level in 25(b), but is less than 110 percent of the Federal poverty level, and whose income for calendar years beginning 1995 is less than 120 percent of the Federal poverty level; and c. Whose resource do no exceed ~~twice~~ three times the maximum standard under SSI, adjusted annually by the increase in the consumer price index.

Citation	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (continued)
1634(e) of the Act	28. ___a. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) or (v) of Section 1611(c)(3)(A) shall be treated, for purposes of title XIX, as receiving SSI benefits for the month. _X_ b. The State applies more restrictive eligibility Individuals whose eligibility for SSI benefits are based solely on disability who are not payable for any months solely by reason of clause (i) or (v) of Section 1611(e)(3)(A), and who continue to meet the more restrictive requirements for Medicaid eligibility under the State plan, are eligible for Medicaid as categorically needy.
1902(a)(10)(eE)(iv), 1905(p)(3)(a)(ii) and 1860D-14(a)(3)(D)	29. Qualifying Individuals - 1 a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act), but not otherwise eligible for Medicaid; b. Who ~~would qualify for coverage under A.25 of Attachment 2.2-A as Qualified Medicare beneficiaries, but~~ has income which is at least 120% but is less than 135% of the Federal poverty level. c. Whose resources do not exceed ~~twice~~ three times the maximum standard under SSI, adjusted annually by the increase in the consumer price index. (Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)

State: Minnesota

Citation	Groups Covered
	A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (continued)
1902(a)(10)(A)(i)(VIII) 1902(k)(2)	30. State Option to Provide Coverage to the Lowest Income Population that Becomes Mandatory in 2014.

Until implementation of the mandatory category in 2014, the state covers: Individuals who are under 65 years of age, not pregnant, not entitled to, or enrolled in, benefits under Part A of title XVIII, or enrolled in benefits under Part B of title XVIII, and not described in 1902(a)(10)(A)(i)(I) through 1902(a)(10)(A)(i)(VII) of the Act, who are non-disabled adults without children and who do not have any other categorical or medically needy basis of eligibility under the Medicaid State Plan and do not have a basis of eligibility under the state's PMAP+ section 1115 waiver.

__X__ The agency elects to make individuals described above eligible under the early option set forth in section 1902(k)(2) of the Act. The effective date for coverage of this group under the early option is March 1, 2011.

The income standard applicable to individuals eligible under this early option is gross income at or below 75% FPL. No resource test is applicable to this group.

In determining whether an individual's income is at or below the State's income standard for this group, the State will use the following methodology:

_____ The income rules of the SSI program.

_____ The income rules of the SSI program, and the following less restrictive income disregards and exclusions than are used by SSI.

__X__ A methodology based on rules other than those of the SSI program. The methodology the State will use is:

- The income exclusion rules of the AFDC program in determining income that is counted and not counted for the gross income limit.
- The state will not apply earned or unearned income disregards and deductions to countable income.

FEB 17 2011

STATE: Minnesota

Agency*	Citations	Groups Covered
		B. Optional Groups Other than the Medically Needy
42 CFR 435.210 1902(a)(10)(A)(ii) and 1905(a) of the Act	/X/ 1.	Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42 CFR 435.230, but who do not receive cash assistance. /X/ The plan covers all individuals as described above. /__/ The plan covers only the following group or groups of individuals: _____ Aged _____ Blind _____ Disabled _____ ~~Caretaker relatives~~ _____ ~~Pregnant women~~
42 CFR 435.211	/X/ 2.	Individuals who would be eligible for AFDC, SSI, or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

*Agency that determines eligibility for coverage.

State: MINNESOTA

Agency* Citation(s)

B. Optional Groups Other than the Medically Needy
(Continued)

42 CFR §435.212 & §1902(e)(2) of the Act

x 3. The State deems as eligible those individuals who become otherwise ineligible for Medicaid while enrolled in ~~an HMO qualified under Title XIII of the Public Health Service Act or while enrolled in an entity described in sections 1903(m)(2)(B)(iii), (E) or (G) or 1903(m)(6) of the Act~~ a managed care organization (MCO) ~~, but who have been enrolled in the HMO or entity for less than the minimum enrollment period listed below. The HMO or entity must have a risk contract as specified in 42 CFR 434.20(a).~~ Coverage under this section is limited to ~~HMO~~ MCO services and family planning services described in section 1905(a)(4)(C) of the Act.

The minimum enrollment period is ~~six months (not to exceed six months)~~ one month, except that it may be two months when timely notice of ineligibility cannot be given until the second month.

The State measures the minimum enrollment period from:

___ The date beginning the period of enrollment in the ~~HMO or other entity~~ MCO, without any intervening disenrollment, regardless of Medicaid eligibility.

x The date beginning the period of enrollment in the ~~HMO~~ MCO as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

___ The date beginning the last period of enrollment in the ~~HMO~~ MCO as a Medicaid patient (not including periods when payment is made under this section), without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

* Agency that determines eligibility for coverage.

State: MINNESOTA

Agency* Citation(s)

B. Optional Groups Other than the Medically Needy (Continued)

§1932(a)(4)
42 CFR §438.56
P.L. 99-272 (section 9517), P.L. 101-58 (section 4732)

The Medicaid agency may elect to restrict the disenrollment rights of Medicaid enrollees of MCOs in accordance with the regulations at 42 CFR §438.56. This requirement applies unless a recipient can demonstrate good cause for disenrolling, or if he/she moves out of the entity's service area, or becomes ineligible.

x Disenrollment rights are restricted for a period of 12 months.

During the first 90 days following the date of initial enrollment in a MCO, the recipient may disenroll once without cause. The State will provide notification, at least once per year, to recipients enrolled in a MCO of their disenrollment rights. The recipient may disenroll without cause at least once every 12 months thereafter.

Additionally, during the first year of initial enrollment in a MCO, the recipient may disenroll once without cause.

___ No restrictions upon disenrollment rights for SSI and Aged, Blind, and Disabled Groups.

* Agency that determines eligibility for coverage.

State: MINNESOTA

Agency*	Citation(s)	B. Optional Groups Other than the Medically Needy (Continued)
	§1903(m)(2)(H), §1902(a)(52), P.L. 101-58, 42 CFR §438.56(g)	In the case of individuals who have become ineligible for Medicaid for the brief period described in §1903(m)(2)(H) and who were enrolled with a MCO when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.
		x The agency elects to reenroll the above individuals who are ineligible in a month but within the succeeding two months become eligible, into the same MCO in which they were enrolled at the time of eligibility was lost.
		___ The agency elects not to reenroll the above individuals into the same entity in which they were previously enrolled.
	42 CFR §435.217	x 4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provisions of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

* Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(VII) of the Act

/ 5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

/ The State covers all individuals as described above.

/ The State covers only the following group o groups of individuals:

___ Aged
___ Blind
___ Disabled
___ Individuals under the age of--
___ 21
___ 20
___ 19
___ 18
___ Caretaker relatives
___ Pregnant women

*Agency that determines eligibility for coverage.

State: MINNESOTA

Agency* Citation	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.220

__ 6. ~~Individuals who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a State agency as a service expenditure. The state's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC.~~

__ ~~The State covers all individuals as described above.~~

1902(a)(10)(A)(ii)
1905(a) of the Act

____ ~~The State covers only the following group or groups of and individuals:~~

____ ~~Individuals under the age of --.~~

____ ~~21~~
____ ~~20~~
____ ~~19~~
____ ~~18~~

____ ~~Caretaker relatives~~
____ ~~Pregnant women~~

42 CFR 435.222
1902(a)(10)(A)(ii) and
1905(a)(i) of the Act

~~7.~~ _X_ a. ~~All individuals who are not described in section 1902(a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are under the age of --~~

~~_X_ 21~~
____ ~~20~~
____ ~~19~~
____ ~~18~~

State: MINNESOTA

Citation	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.222 _X_ 7.b. Reasonable classifications of individuals Described in (a) above, as follows:

____ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

____ (a) In foster homes (and are under the age of __).

____ (b) In private institutions (and are under the age of __).

____ (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of __).

_X_ ~~(2) Individuals who are under the age of 21 in adoptions subsidized in full or in part by a public agency, without regard to income or assets, who cannot be placed without medical assistance because the child has special needs for medical or rehabilitative care. Under the Interstate Compact for Adoption and Medical Assistance, individuals under the age of 21 in adoptions subsidized in full or in part by a public agency of another state when that state's adoption assistance agreement includes coverage of medical assistance.~~

____ (3) Individuals in NFs (who are under the age of __). NF services are provided under this plan.

____ (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of __).

Citation | Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

_____ (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of _____). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

__X__ (6) Other defined groups and ages as specified in **Supplement 1** of Attachment 2.2-A.

State: MINNESOTA

Citation		Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
1902(a)(10)(A)(ii)(VIII)	~~X~~	~~8. A child for whom there is in effect a State adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement –~~ ~~a. Was eligible for Medicaid under the State's approved Medicaid Plan; or~~ ~~b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies.~~ ~~The State covers individuals under the age of –~~ ~~X 21~~ ~~___ 20~~ ~~___ 19~~ ~~___ 18~~

State: MINNESOTA

Agency* Citation	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.223 ___ 9. ~~Individuals described below who would be eligible for AFDC~~ if ~~coverage under the State's AFDC plan were a broad as allowed under title IV-A:~~

1902(a)(10)(A)(ii) and 1905(a) of the Act

___ ~~Individuals under the age of --~~
___ ~~21~~
___ ~~20~~
___ ~~19~~
___ ~~18~~

___ ~~Caretaker relatives~~
___ ~~Pregnant women~~

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.230 /_/ 10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in the State.

d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

___ (1) All aged individuals.

___ (2) All blind individuals.

___ (3) All disabled individuals.

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
		___ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
	42 CFR 435.230	___ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
		___ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
		___ (7) Individuals receiving a Federally administered optional State supplemen that meets the conditions specified i 42 CFR 435.230.
		___ (8) Individuals receiving a State administered optional State supplemen that meets the conditions specified i 42 CFR 435.230.
		___ (9) Individuals in additional classifications approved by the Secretary as follows:

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

The supplement varies in income standard by politica subdivisions according to cost-of-living differences

___ Yes.

___ No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.230
435.121
1902(a)(10)(A)(ii)(XI) of the Act

/X/ 11. Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act.

The following groups of individuals who receiv a State supplementary payment under an approve optional State supplementary payment program that meets the following conditions. The supplement is--

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the incom standard used to determine eligibility for the supplement.

c. Available to all individuals in each classification and available on a Statewide basis.

d. Paid to one or more of the classifications of individuals listed below:

X (1) All aged individuals.

X (2) All blind individuals.

X (3) All disabled individuals.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

___ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (7) Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

___ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

___ (9) Individuals in additional classifications approved by the Secretary as follows:

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

___ Yes

_X_ No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

State: MINNESOTA

Citation	Groups Covered

B. Optional Coverage Other Than the Medically Needy (Continued)

42 CFR 435.230
1902(a)(10)(A)(ii)(V)
of the Act.

/X/ 12. Individuals who are in a medical institution for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in supplement 1 to Attachment 2.6-A.

/ / The State covers all individuals as described above.

/X/ The State covers only the following group or groups of individuals.

1902(a)(10)(A)(ii)
and 1905(a) of the Act

_X_ Aged
____ Blind
____ Disabled
____ Individuals under the age of --

____ 21
____ 20
____ 19
____ 18

____ Caretaker relatives
____ Pregnant women

Agency*	Citation(s)		Groups Covered
			B. Optional Groups Other Than the Medically Needy (Continued)
	1902(e)(3) of the Act	/X/	13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act. Supplement 3 to ATTACHMENT 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.
	1902(a)(10)(A)(ii)(IX) and 1902(l) of the Act	/_/	14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in Supplement to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A: a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and b. Infants under one year of age.

Citation	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(IX) and 1902(l)(1)(D) of the Act

~~X~~ ~~15~~. ~~The following individuals who are not mandatory categorically needy, who have income that does not exceed the income level (established at an amount up to 100 percent of the Federal poverty level) specified in Supplement 1 of Attachment 2.6-A for a family of the same~~

~~Children who are born after September 30, 1983 and who have attained 6 years of age but have not attained 19 years of age.~~

___ ~~7 years of age; or~~

___ ~~8 years of age.~~

State: MINNESOTA

Agency* Citation(s)		Groups Covered
	B.	**Optional Groups Other Than the Medically Needy** (Continued)
1902(a)(10)(A)(ii)(X) and 1902(m)(1) and (3) of the Act	X	16. Individuals - a. Who are 65 years of age or older or who are disabled, As determined under section 1614(a)(3) of the Act. Both Aged and disabled individuals are covered under this eligibility group. b. Whose income does not exceed the income level specified in Supplement 1 to ATTACHMENT 2.6-A (95 percent) as a percent of the Federal income poverty level for a family of the same size; and c. Whose resources do not exceed the maximum amount allowed under the State's medically needy category for aged, blind and disabled.

State: MINNESOTA

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(47) and 1920 of the Act	~~17.~~	~~Pregnant women who are determine by a "qualified provider" as defined in §1920(b)(2) of the Act) based on~~ preliminary ~~information, to meet the highest applicable income criteria specified in this plan under Attachment 2.6-A and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with 1920 of the Act.~~

Citation	Condition or Requirement
	B. Optional Groups Other Than the Medically Needy (Continued)
§1906 of the Act	[ ] ~~18~~. ~~Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum period of _____ months.~~
§1902(as)(10)(F) and §1902(u)(1) of the Act	[ ] ~~19~~. ~~Individuals entitled to elect COPBRA continuation coverage and whose income as determined under 1602 of the Act for purposes of the SSI program, is no more than 100% of the Federal poverty level, whose resources are no more than twice the SSI resource list for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A.~~

Note: pre-print page deemed obsolete by CMS.

State: MINNESOTA

Citation	Groups Covered

B. Optional Coverage Other than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(XIV) of the Act

X ~~19.~~ ~~Optional Targeted Low-Income Children, who:~~

a. ~~are not eligible for Medicaid under any other optional or mandatory group or eligible as medically needy (without spenddown liability);~~

b. ~~Would not be eligible for Medicaid under the policies in the State's Medicaid plan as in effect on April 15, 1997 (other than because of the age expansion provided for in 1902(l)(2)(D));~~

c. ~~Are not covered under a group health plan or other group health insurance (as such terms are defined in 2791 of the Public Health Service Act coverage) other than under a health insurance program in operation before July 1, 1997 offered by a State which receives no Federal funds for the program;~~

d. ~~Have family income at or below: 200 percent of the Federal poverty level for the size family involved, as revised annually in the Federal Register; or~~

~~A percentage of the Federal poverty level, which is in excess of the "Medicaid applicable income level" (as defined in 2110(b)(4) of the Act) but by no more than 50 percentage points.~~

~~The State covers:~~

X ~~All children under age 2 described above, with family income which is at or below 280% of the Federal poverty level, but greater than the income level for poverty level infants under the age of one in the Medicaid State plan established by 1902(r)(2) methodology (185% of federal poverty as specified in Supplement 1 to Attachment 2.6-A, and with additional disregards to equal 275% of federal poverty as specified in Supplement 8a to Attachment 2.6-A, page 2), and made applicable to children under the age of two by the 1115 Minnesota Health Care Reform Waiver, approved 4/27/95.~~

State: MINNESOTA

Agency* Citation(s)		Groups Covered
	B.	Optional Groups Other Than the Medically Needy (Continued)
1902(a)(10)(A)(ii)(XIII) of the Act	X	20. Disabled individuals whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See page 12c of Attachment 2.6-A.

State/Territory: Minnesota

Citation	Groups Covered
B.	Optional Groups Other Than the Medically Needy (Continued)
1902(a)(10)(A) (ii)(XIII) of the Act and 1905(a)(vii)	[X] 21. BBA Work Incentives Eligibility Group - Individuals with a disability whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. Individuals must be disabled as defined by the rules of the Supplemental Security Income (SSI) program. See page 12c of Attachment 2.6-A.
1902(a)(10)(A) (ii)(XV) of the Act	[~~X~~] 22. TWWIIA Basic Coverage Group - Individuals with a disability at least 16 but less than 65 years of age whose income and resources do not exceed a standard established by the State. See page 12d of Attachment 2.6-A.
1902(a)(10)(A) (ii)(XVI) of the Act	[ ] 23. TWWIIA Medical Improvement Group - Employed individuals at least 16 but less than 65 years of age with a medically improved disability whose income and resources do not exceed a standard established by the State. See page 12h of Attachment 2.6-A. NOTE: If the State elects to cover this group, it MUST also cover the Basic Coverage Group described in no. 24 above.

(per State authorization, CMS corrected numbering format. Item #21, 22, 23 was listed as 23, 24, 25 in error. S. Porter 09-06-18)

STATE: MINNESOTA

Citation		Groups Covered
		B. Optional Coverage Other Than the Medically Needy (Continued)
1902 (a) (10) (A) (ii) (XVIII) of the Act	X	[24]. Women who: a. have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix; b. are not otherwise covered under creditable coverage, as defined in section 2701 (c) of the Public Health Service Act; c. are not eligible for Medicaid under any mandatory categorically needy eligibility group; and d. have not attained age 65.
1920B of the Act	X	[25]. Women who are determined by a "qualified entity" (as defined in 1920B (b) based on preliminary information, to be a woman described in 1902 (aa) the Act related to certain breast and cervical cancer patients. The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.

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Agency*	Citation(s)	Groups Covered
		C. Optional Coverage of the Medically Needy
	42 CFR 435.301	This plan includes the medically needy.
		/_/ No.
		/X/ Yes. This plan covers:
		1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.
	1902(e) of the Act	2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.
	1902(a)(10)(C)(ii)(I) of the Act	3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.

State: MINNESOTA

Citation	Groups Covered

C. Optional Coverage of Medically Needy (Continued)

~~1902(e)(4) of the Act~~

4. ~~Newborn children born on or after October 1, 2984 to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as the woman remains eligible and the child is a member of the woman's household.~~

42 CFR 435.308

5. [X] a. Financially eligible individuals who are not described in section C.3. above and who are under the age of --

_X_ 21
_____20
_____19
_____18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

[X] b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:

___(1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

____(a) In foster homes (and are under the age of ____).

____(b) In private institutions (and are under the age of ____).

Citation | Groups Covered

C. Optional Coverage of the Medically Needy (Continued)

_____ (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of _____).

_____ (3) Individuals in NFs (who are under the age of _____). NF services are provider under this plan.

_____ (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of _____).

_____ (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ___). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

__X__ (6) Other defined groups and ages as specified in **Supplement 1** of Attachment 2.2-A.

Agency*	Citation(s)	Groups Covered

C. Optional Coverage of Medically Needy (Continued)

42 CFR 435.310 /X/ 6. Caretaker relatives.

42 CFR 435.320 and 435.330 /X/ 7. Aged individuals.

42 CFR 435.322 and 435.330 /X/ 8. Blind individuals.

42 CFR 435.324 and 435.330 /X/ 9. Disabled individuals.

42 CFR 435.326 /_/ 10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.

435.340 11. Blind and disabled individuals who:

a. Meet all current requirements for Medicaid eligibility except the blindness or disabilit criteria;

b. Were eligible as medically needy in December 1973 as blind or disabled; and

c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.

State: MINNESOTA

Citation	Condition or Requirement
	C. Optional Coverage of Medically Needy (continued)
§1906 of the Act	[ ] 12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of ___ months.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Agency	Citation (s)	Groups Covered
1935(a) and 1902(a)(66) 42 CFR 423.774 and 423.904	The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act. 1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act; 2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined; 3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Minnesota

Reasonable Classifications of Individuals Under the Age of 21, 20, 19 and 18

B.7(b)(6): Optional Groups Other Than the Medically Needy

Optional Disabled Children under age 19.

1902(a)(10)(A)(ii)(X), 1902(e)(3) 1905(a)(i) of the Act

Children under age 19, who would be eligible for Medicaid under the plan if they were in a medical institution, who meet the criteria under section 1902(e)(3) and for whom the state has made a determination as required under section 1902(e)(3)(B), who have an income level at or below the level in §1902(m) specified in Supplement 1, page 5 to Attachment 2.6-A using the state's more restrictive income requirements for Medicaid than SSI specified in Supplement 4 to Attachment 2.6-A, and the less restrictive methods specified in Supplement 8a to Attachment 2.6-A.

Optional Children under Age 21 Who Would be Institutionalized but for Home and Community-based Services.

1902(a)(10(A)(ii)(VI) and (X) and 1905(a)(i)

Children who would be eligible for Medicaid under the plan if they were in a medical institution and who, but for the receipt of home and community-based services under a waiver granted under 42 CFR Part 441 would require care in a medical institution, and who will receive services under the waiver; who have an income level at or below the level of §1902(m) specified in Supplement 1, page 5 to Attachment 2.6-A, using the state's more restrictive income requirements for Medicaid than SSI specified in Supplement 4 to Attachment 2.6-A, and the less restrictive income methods specified in Supplement 8a to Attachment 2.6-A.

C.5(b)(6): Optional Coverage of Medically Needy

Medically Needy Disabled Children under Age 19

1902(a)(10)(C) 1905(a)(i) and

Children who are under age 19, who would be eligible for Medicaid under the plan if they were in a medical institution, who meet the criteria under section 1902(e)(3) and for whom the state has made a determination as required under section 1902(e)(3)(B), who have an income level at or below the medically needy level applicable to the disabled in Supplement 1, page 6 to Attachment 2.6-A, using the state's more restrictive income requirements for Medicaid than SSI specified in Supplement 4 to Attachment 2.6-A, and the less restrictive methods specified in Supplement 8a to Attachment 2.6-A.

Medically Needy Children under Age 21 Who Would be Institutionalized bur for Home and Community-based Services

1902(a)(10(C) 1905(a)(i)

Children who would be eligible for Medicaid under the plan if they were in a medical institution and who, but for the receipt of home and community-based under a waiver granted under 42 CFR Part 441, would require care in a medical institution, and who will receive services under the waiver; and who have an income level at or below the medically needy level applicable to the disabled in Supplement 1, page 6 to Attachment 2.6-A, using the state's more restrictive income requirements for Medicaid than SSI specified in Supplement 4 to Attachment 2.6-A, and the less restrictive income methods specified in Supplement 8a to Attachment 2.6-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: MINNESOTA

Method for Determining Cost Effectiveness of Caring for Certain Disabled Children At Home

The State Medical Review Team (SMRT) makes two determinations concerning the child's eligibility for TEFRA eligibility.

1. Whether or not the child has one or more conditions which meet or exceed the Supplemental Security Income disability criteria for children.

2. Whether the child requires a level of health care in order to remain at home which compares to the level of care provided by a hospital, a nursing facility, or an intermediate care facility for the mentally retarded (ICF/MR). The comparable level of care is defined at Minnesota Statutes, § 256B.055.

The determination is based on information supplied to the SMRT by the case manager, if the child has one; by the child's parent or guardian; from any screening information that may have been obtained for an application for home and community based services; by the child's school; and by the child's physicians.

Approximately 85 percent of the TEFRA families have other insurance and third party liability functions are performed.

The cost of services provided must be expected to be no more than the level of institutional care that would otherwise be required. Cost effectiveness is determined based on a review of the individual care plan and a determination of medical necessity made by the child's physician.

Revision: HCFA-PM-94-5 (MB)
APRIL 1994

State: MINNESOTA

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation

3.1 Amount, Duration, and Scope of Services

42 CFR Part 440, Subpart B, 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 400, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(1) Categorically needy.

Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:

1902(a)(10)(A) and 1905(a) of the Act

(i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of the mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

___ Not applicable. Nurse-midwives are not authorized to practice in this State.

Revision: HCFA-PM-91-4 (BPD) August 1991 OMB No.: 0938-

State: MINNESOTA

Citation	3.1(a)(1)		Amount, Duration, and Scope of Services: Categorically Needy (continued)
1902(e)(5) of the Act		(iii)	Pregnancy-related, including family family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.
	x	(iv)	Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.
1902(a)(10)(F)(VII) of the Act		(v)	Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provisions of sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

Revision: HCFA-PM-92-7 (MB)
October 1992

State: MINNESOTA

Citation			3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)
1902(a)(10)(D)		(vi)	Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.
1902(e)(7) of the Act		(vii)	Inpatient services that are being furnished to infants and children described in section 1902(1)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.
1902(e)(9)of the Act	___	(viii)	Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1902(a)(52) and 1925 of the Act		(ix)	Services are provided to families eligible under §1925 of the Act as indicated in item 3.5 of this plan.
1905(a)(23) and and 1929 of the Act	___	(x)	Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.
1905(a)(26) and 1934 of the Act	___	(xi)	Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 5 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specified all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: MINNESOTA

Citation 3.1 Amount, Duration, and Scope of Services (continued)

42 CFR Part 440, Subpart B (a)(2) Medically needy.

/X/ This State plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.

Services for the medically needy include:

1902(a)(10)(C)(iv) of the Act, 42 CFR 440.220 (i) If services in an institution for mental diseases (42 CFR 440.140 and 440.160) or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1)through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.

/ / Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.

1902(e)(5) of the Act (ii) Prenatal care and delivery services for pregnant women.

Revision: HCFA-PM-91-4 (BPD) August 1991 OMB No.: 0938-

State: MINNESOTA

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

x (iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.

___ Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

1902(a)(10)(D) of the Act (vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

42 CFR 440.140, 440.150, 440.160, 42 CFR 440, Subpart B; 1902(a)(10)(C) and (21) of the Act

x (vii) Services in an institution for mental diseases for individuals over age 65.

x (viii) Services in an intermediate care facility for the mentally retarded.

x (ix) Inpatient psychiatric services for individuals under age 21.

TN No. 98-01
Supersedes TN No. 91-28

Approval Date 6/2/98 Effective Date 01/01/98

Revision: HCFA-PM-93-5 (MB)
MAY 1993

State: MINNESOTA

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1902(e)(9) of the Act	___	(x)	Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1905(a)(23) and 1929 of the Act	___	(xi)	Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.
1905(a)(26) and 1934 of the Act	___	(xii)	Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 5 to Attachment 3.1-B.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

State: Minnesota

Citation	3.1 Amount, Duration, and Scope of Services (continued)
1902(a)(10)(E)(i) and clause (VIII) of the matter following (F), beneficiaries and 1905(p)(3) of the Act	(a)(3) Other Required Special Groups: Qualified Medicare Beneficiaries Medicare cost sharing for qualified Medicare described in section 1905(p) of the Act is provided only as indicated in item 3.2 of this plan.
1902(a)(10)(E)(ii) and 1905(s) of the Act	(a)(4) (i) Other Required Special Groups: Qualified Disabled and Working Individuals Medicare Part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act	(ii) Other Required Special Groups: Specified Low-Income Medicare Beneficiaries Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10)(E)(iv)(I)1905(p)(3)(A)(ii), and 1933 of the Act	(iii) Other Required Special Groups: Qualifying Individuals - 1 Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv) (I) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.
~~1902(a)(10)(E)(iv)(II), 1905(p)(3)(A)(iv)(II), 1905(p)(3) the Act~~	~~(iv) Other Required Special Groups: Qualifying Individuals - 2~~ ~~The portion of the amount of increase to the Medicare Part B premium attributable to the Home Health provisions for qualifying individuals described in 1902(A)(10)(E)(iv) (II) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.~~
1925 of the Act	(a)(5) Other Required Special Groups: Families Receiving Extended Medicaid Benefits Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991

QMB No.: 0938

State: Minnesota

Citation	
1902(a) and 1903(v) of the Act and Section 401(b)(1)(A) of P. L. 104-193	(a)(6) Limited Coverage for Certain Aliens (i) An alien who is not a qualified alien or who is a qualified alien, as defined in section 431(b) of P. L. 104-193, but is not eligible for Medicaid based on alienage status, and who would otherwise qualify for Medicaid is provided Medicaid only for the treatment of emergency medical conditions. (including labor and delivery as defined in section 1903(v) of the Act.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State: MINNESOTA

Citation		3.1 Amount, Duration, and Scope of Services (Continued)
1905(a)(9) of the Act		(a)(7) Homeless Individuals Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.
1902(a)(47) and 1920 of the Act	___	(a)(8) Presumptively Eligible Pregnant Women Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.
42 CFR 441.55 50 CFR 43654 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act		(a)(9) EPSDT Services The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

State/Territory: MINNESOTA

Citation	3.1(a)(9)	Amount, Duration, and Scope of Services: EPSDT Services (continued)
42 CFR 441.60	x	The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements. Methods employed to assure the providers' compliance with their agreements are the same as those used for providers' compliance of other Medical Assistance services. In addition, as required under federal quality assurance provisions for ~~HMO~~ MCO contracts, an independent, contracted audit is performed on randomly selected charts for Medical Assistance enrollees in managed care. Providers must submit encounter data and referral information. The Department monitors claims data from all providers for completion of EPSDT services. Results are compared to national norms.
42 CFR 440.240 and 440.250	(a)(10)	Comparability of Services
1902(a) and 1902(a)(10), 1902(a)(52), 1903(v), 1915(g), ~~and~~ 1925(b)(4), and 1932 of the Act		Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915 and 1925, and 1932 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions: (i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person. (ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy. (iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State/Territory: MINNESOTA

(a)(10) Comparability of Services (continued)

x (iv) Additional coverage for pregnancy-related services and services for conditions that may complicate pregnancy are equal for categorically and medically needy.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

Citation
42 CFR Part 440, Subpart B
42 CFR 441.15
AT-78-90
AT-80-34

3.1(b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

(1) Home health services are provided to all categorically needy individuals 21 years of age or over.

(2) Home health services are provided to all categorically needy individuals under 21 years of age.

☒ Yes

☐ Not applicable. The State plan does not provide for skilled nursing facility services for such individuals.

(3) Home health services are provided to the medically needy:

☒ Yes, to all

☐ Yes, to individuals age 21 or over; SNF services are provided

☐ Yes, to individuals under age 21; SNF services are provided

☐ No; SNF services are not provided

☐ Not applicable; the medically needy are not included under this plan

TN # 79-22
Supersedes
TN #

Approval Date 12.3.79 Effective Date 10-2-79

Revision: HCFA-PM-93-8 (BPD)
December 1993

State/Territory: MINNESOTA

Citation 3.1 Amount, Duraction, and Scope of Services (continued)

42 CFR 431.53 (c)(1) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-D.

42 CFR 483.10 (c)(2) Payment for Nursing Facility Services

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10(c)(8)(i).

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

Citation		
42 CFR 440.260 AT-78-90	3.1(d)	Methods and Standards to Assure Quality of Services The standards established and the methods used to assure high quality care are described in ATTACHMENT 3.1-C.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

Citation		
42 CFR 441.20 AT-78-90	3.1(e)	Family Planning Services The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

TN # 76-31
Supersedes
TN #

Approval Date 1-17-77 Effective Date 10-1-76

Revision: HCFA-PM-87-5 (BERC) OMB No.: 0938-0193
April 1987

State/Territory: Minnesota

Citation 3.1(f)
42 CFR 441.30

(1)Optometric Services
Optometric services (other than those provided under §§ 435.531 and 436.531 are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

[X] Yes.

[ ] No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

[X] Not applicable. The conditions in the first sentence do not apply.

1903(i) (1) of the Act, P.L. 99-272 (Section 9507)

(2) Organ Transplant Procedures
Organ transplant procedures are provided.

[ ] No

[X] Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.

State: MINNESOTA

Citation
42 CFR 431.110(b) 3.1 (g) Participation by Indian Health Service Facilities
AT-78-90

Indian Health Service facilities (which include, effective July 11, 1996, at the option of a tribe, facilities owned or operated by a tribe or tribal organization, and funded by Title I or III of the Indian Self-Determination and Education Assistance Act, P.L. 98-638, as amended, operating as 638 facilities) are accepted as providers, in accordance with 42 CFR 431.110(b) on the same basis as other qualified providers.

1902(e)(9) of the Act, P.L. 99-509 (Section 9408) (h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in Section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who --

(1) Are medically dependent on a ventilator for life support at least six hours per day;

(2) Have been do dependent as inpatients during a single stay or a continuous stay in one or more hospitals, NFS or ICFs for the lesser of --

☐ 30 consecutive days;

☐ __ days (the maximum number of inpatient days allowed under the State plan);

(3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, NF, or ICF for which Medicaid payments would be made;

(4) Have adequate social support services to be cared for at home; and

(5) Wish to be cared for at home.

☐ Yes. The requirements of Section 1902(e)(9) of the Act are met.

☒ Not applicable. These services are not included in the plan.

Revision: HCFA-PM-93-5 (MB)
MAY 1993

State: MINNESOTA

Citation

3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902(a)(10)(E)(i) and 1905(p)(1) of the Act

(i) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Buy-in agreement for:

x Part A x Part B

___ The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: Minnesota

Citation	
1902(a)(10)(E)(ii) and 1905(s) of the Act	(ii) Qualified Disabled and Working Individual (QDWI) The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-E, for individuals in the QDWI group defined in item A.26 of ATTACHMENT 2.2-A of this plan.
1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act	(iii) Specified Low-Income Medicare Beneficiary (SLMB) The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan.
1902(a)(10)(E)(iv)(I), 1905(p)(3)(A)(ii), and 1933 of the Act	(iv) Qualifying Individual-1 (QI-1) The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act.
~~1902(a)(10)(E)(iv)(II), 1905(p)(3)(A)(ii), and 1933 of the Act~~	~~(v) Qualifying Individual-2 (QI-2)~~ ~~The Medicaid agency pays the portion of the amount of increase to the Medicare Part B premium attributable to the Home Health Provision to the individuals described in 1902(a)(10)(E)(iv)(II) and subject to 1933 of the Act.~~

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: Minnesota

Citation

1843(b) and 1905(a) of the Act and 42 CFR 431.625

~~(vi)~~ (v) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

X All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); b) receiving State supplements under title XVI; or c) withing a group listed at 42 CFR 431.625(d)(2).

_ Individuals receiving title II or Railroad Retirement benefits.

_ Medically needy individuals (FFP is not available for this group).

1902(a)(30) and 1905(a) of the Act

(2) Other Health Insurance

X The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

Revision: HCFA-PM-93-2 (CMSO)
March 1993

State: Minnesota

Citation

(b) Deductibles/Coinsurance

1843(b) and 1905(a) of the Act and 42 CFR 431.625

(1) **Medicare Part A and B**

Supplement 1 to Attachment 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups. Medicaid agency pays Medicare Part B premiums

Sections 1902(a)(10)(E)(i) And 1905(p)(3) of the Act

(i) **Qualified Medicare Beneficiaries (QMBs)**

The Medicaid agency pays Medicare part A and Part B deductibles and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

1902(a)(10), 1902(a)(30) and 1905(a) of the Act

(ii) **Other Medicaid Recipients**

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)~~(iv)~~(v), payment is made as follows:

42 CFR 431.625

_____ For the entire range of services available under Medicare Part B.

__X__ Only for the amount, duration, and scope of services otherwise available under this plan.

1902(a)(10), 1902(a)(30) and and 1905(p) of the Act

(2) **Dual Eligible – QMB Plus**

The Medicaid agency pays Medicare Part A and B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).

TN No. 12-02
Supersedes:
TN No. 93-08

Approval Date: MAY 14 2012 Effective Date: 01/01/2012

Revision: HCFA-PM-91-8 (MB) OMB No.:
October 1991

State: MINNESOTA

Citation		Condition or Requirement
§1906 of the Act	(c)	Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans. When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22(h).
§1902(a)(10)(F) of the Act	(d)	[ ] The Medicaid agency pays premiums for individuals described in item B.19 of Attachment 2.2-A.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

Citation
42 CFR 441.101,
42 CFR 431.620(c)
and (d)
AT-79-29

3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

☒ Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620(c) and (d) are met.

☐ Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

Citation
42 CFR 441.252
AT-78-99

3.4 Special Requirements Applicable to Sterilization Procedures

All requirements of 42 CFR Part 441, Subpart F are met.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State: MINNESOTA

Citation
1902(a)(52) and 1925 of the Act

3.5 Families Receiving Extended Medicaid Benefits

(a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are--

/X/ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

/ / Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

/ / Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

/ / Medical or remedial care provided by licensed practitioners.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State: MINNESOTA

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

- [/] Home health services.
- [/] Private duty nursing services.
- [/] Physical therapy and related services.
- [/] Other diagnostic, screening, preventive, and rehabilitation services.
- [/] Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.
- [/] Intermediate care facility services for the mentally retarded.
- [/] Inpatient psychiatric services for individuals under age 21.
- [/] Hospice services.
- [/] Respiratory care services.
- [/] Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State: MINNESOTA

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

(c)☑ The agency pays the family's premiums, enrollmen fees, deductibles, coinsurance, and similar cost for health plans offered by the caretaker's employer as payments for medical assistance--

☑ 1st 6 months ☑ 2nd 6 months

☑ The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.

☑ 1st 6 mos. ☑ 2nd 6 mos.

(d)☑ (1) The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

☑ Enrollment in the family option of an employer's health plan.

☑ Enrollment in the family option of a State employee health plan.

☑ Enrollment in the State health plan for the uninsured.

☑ Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

Revision: HCFA-PM-91-4 (BPD)
August 1991

OMB No.: 0938-

State: MINNESOTA

Citation 3.5 Families Receiving Extended Medicaid Benefits (continued)

Supplement 4 to ATTACHMENTS 3.1-A and 3.1-B specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency --

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

___ (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

State/Territory: MINNESOTA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: /_/No limitations /X/ With limitations*

2.a. Outpatient hospital services.

Provided: /_/No limitations /X/ With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State plan).

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Provided: /_/ No limitations /X/With limitations*

3. Other laboratory and x-ray services.

Provided: /_/ No limitations /X/With limitations*

State/Territory: MINNESOTA

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: __ No limitations _x_ With limitations*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4.c. Family planning services and supplies for individuals of child-bearing age.

Provided: __ No limitations _x_ With limitations*

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: __ No limitations _x_ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: __ No limitations _x_ With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Provided: __ No limitations _x_ With limitations:

* Description provided on attachment.

State/Territory: MINNESOTA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

c. Chiropractors' services.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

d. Other practitioners' services.

/X/ Provided: Identified on attached sheet with description of limitations, if any.

/_/ Not provided.

. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: /_/No limitations /X/With limitations*

b. Home health aide services provided by a home health agency.

Provided: /_/No limitations /X/With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: /_/No limitations /X/With limitations*

*Description provided on attachment.

State/Territory: MINNESOTA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

8. Private duty nursing services.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

10. Dental services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

b. Occupational therapy.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

b. Dentures.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

c. Prosthetic devices.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

d. Eyeglasses.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

*Description provided on attachment.

State/Territory: MINNESOTA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

☑ Provided: ___ No limitations _x_ With limitations*
☐ Not provided.

c. Preventive services.

☑ Provided: ___ No limitations _x_ With limitations*
☐ Not provided.

d. Rehabilitative services.

☑ Provided: ___ No limitations _x_ With limitations*
☐ Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

☑ Provided: ___ No limitations _x_ With limitations*
☐ Not provided.

b. ~~Skilled~~ Nursing facility services.

☑ Provided: ___ No limitations _x_ With limitations*
☐ Not provided.

c. Intermediate care facility services.

☑ Provided: ___ No limitations _x_ With limitations*
☐ Not provided.

* Description provided on attachment

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15.a. ~~Intermediate care~~ Nursing facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)~~(A)~~ of the Act, to be in need of such care.

☒ Provided: ____ No limitations _x_ With limitations*
☐ Not provided.

b. ~~Including such~~ Intermediate care facility services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☒ Provided: ____ No limitations _x_ With limitations*
☐ Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ Provided: ____ No limitations _x_ With limitations*
☐ Not provided.

17. Nurse-midwife services.

☒ Provided: ___ No limitations _x_ With limitations*
☐ Not provided.

18. Hospice care (in accordance with section 1905(o) of the Act).

☒ Provided: ___ No limitations _x_ With limitations*
☐ Not provided.

* Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and tuberculosis related services

a. Case management services as defined in, and to the groups specified in, Supplements 1 through ~~1C~~ 1d to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

x Provided: x With limitations

___ Not provided.

b. Special tuberculosis (TB)-related services under section 1902(z)(2)(F) of the Act.

x Provided: x With limitations*

___ Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

x Additional coverage++

b. Services for any other medical conditions that may complicate pregnancy.

x Additional coverage++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

* Description provided on attachment.

State/Territory: MINNESOTA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a eligible provider (in accordance with section 1920 of the Act).

/ / Provided: / / No limitations / /With limitations*

/X/ Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

/ / Provided: / / No limitations / /With limitations*

/X/ Not provided.

23. Certified pediatric or family nurse practitioners' services.

/X/ Provided: / / No limitations /X/With limitations*

*Description provided on attachment.

State/Territory: MINNESOTA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

☒ Provided: ___ No limitations _x_ With limitations*
☐ Not provided.

b. Services of ~~Christian Science~~ nurses in religious nonmedical health care institutions.

☐ Provided: ___ No limitations ___ With limitations*
☒ Not provided.

c. Care and services provided in ~~Christian Science sanitoria~~ religious nonmedical health care institutions.

☒ Provided: _x_ No limitations ___ With limitations*
☐ Not provided.

d. Nursing facility services for patients under 21 years of age.

☒ Provided: ___ No limitations _x_ With limitations*
☐ Not provided.

e. Emergency hospital services.

☒ Provided: ___ No limitations _x_ With limitations*
☐ Not provided.

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described, and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

☐ Provided ☒ Not provided

* Description provided on attachment.

State/Territory: MINNESOTA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are: (A) authorized for the individual by a physician in accordance with a plan of treatment; (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (C) furnished in a home.

☒ Provided:

___ State approved (not physician) Service Plan allowed

_x_ Services outside the home also allowed

_x_ Limitations described on Attachment

☐ Not provided.

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 5 to Attachment 3.1-A.

☐ Provided ☒ Not provided

State/Territory: MINNESOTA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

28. Freestanding Birth Center Services

☒ Provided: ___ No limitations x With limitations*
☐ Not provided.

29. Integrated Care Models

☒ Provided: ___ No limitations x With limitations*
☐ Not provided.

*Description provided on attachment.

LIMITATIONS TO THE AMOUNT, DURATION, AND SCOPE OF COVERED SERVICES
(Referenced by the number of the service described in preceding pages)

1. Inpatient hospital services:

- Certification of admission is a condition of payment. Inpatient stays not deemed medically necessary by the state agency or the designated medical review agent are not covered.

- Inpatient chemical dependency treatment ~~will require at least 30 hours per week of therapy/counseling including group, collateral, and individual therapy/counseling~~ is provided according to state licensing and chemical dependency service requirements for individual client treatment that define treatment progress and continued clinical need.

- Hospitals must comply with federal regulations concerning informed consent and statements of acknowledgment for voluntary sterilization procedures, hysterectomies, and therapeutic abortions.

- Detoxification is covered only when inpatient hospitalization is medically necessary because of conditions resulting from withdrawal or conditions occurring in addition to withdrawal, e.g., conditions resulting from injury or accident or medical complications during detoxification such as delirium that necessitate the constant availability of physicians and registered nurses and/or complex medical equipment found only in an inpatient setting.

- Leave days, leaves of absence, and reserve beds are not covered.

- A private room must be certified by a licensed physician to be medically necessary, unless the hospitals private room rate does not exceed its semi-private room rate.

1. Inpatient hospital services. (continued)

- Abortion related services are covered: ~~when the abortion is medically necessary to prevent the death of a pregnant woman when such pregnant woman suffers from a physical disorder, injury or illness, and in cases where the pregnancy is the result of rape and incest. Cases of rape and incest must be reported to legal authorities unless the treating physician documents that the woman was physically or psychologically unable to report.~~
(1) if the pregnancy is the result of an act of rape or incest; or
(2) in the case where a person suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the person in danger of death unless an abortion is performed.

- Laboratory, x-ray, and any additional services provided as a result of a recipient's scheduled visit that immediately precedes hospital admission as an inpatient are not covered as separate services.

- Providers who administer pediatric vaccines as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program,

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2.a. Outpatient hospital services. (continued)

- Abortion related services are covered: ~~when the abortion is medically necessary to prevent the death of a pregnant woman when such pregnant woman suffers from a physical disorder, injury or illness, and in cases where the pregnancy is the result of rape and incest. Cases of rape and incest must be reported to legal authorities unless the treating physician documents that the woman was physically or psychologically unable to report.~~
  (1) if the pregnancy is the result of an act of rape or incest; or
  (2) in the case where a person suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the person in danger of death unless an abortion is performed.

- Coverage of physical therapy, occupational therapy, audiology, and speech language pathology is limited to services within the limitations provided under items 11.a. ·to 11.c., physical therapy and related services.

- Providers who administer pediatric vaccines.as noted in item 5.ai, Physician ' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

2.a. Outpatient hospital services. (continued)

- Abortion related services are covered when the abortion is medically necessary to prevent the death of a pregnant woman~~,~~ when such pregnant woman suffers from a physical disorder, injury or illness, and in cases where the pregnancy is the result of rape and incest. Cases of rape and incest must be reported to legal authorities unless the treating physician documents that the woman was physically or psychologically unable to report.

- Coverage of physical therapy, occupational therapy, audiology, and speech language pathology is limited to services within the limitations provided under items 11.a. to 11.c., physical therapy and related services.

- Providers who administer pediatric vaccines as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

2.b. Rural and other ambulatory services that are covered under the plan and furnished by a rural health clinic.

- All health services provided by a rural health clinic are covered services within the limitations applicable to the same services as other medical assistance providers, if the rural health clinic's staffing requirements and written policies governing health services provided by personnel other than a physician are in compliance with 42 CFR §491.

- Providers who administer ~~the~~ pediatric vaccines ~~listed~~ as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC.

- All covered services are subject to the same limitations to amount, duration, and scope applicable to other providers of the same service.

- Providers who administer ~~the~~ pediatric vaccines ~~listed~~ as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

3. Other laboratory and x-ray services.

Coverage is limited to:

1) Laboratory services provided by ~~a Medicare certified laboratory. In addition, such services must be provided by~~ laboratories that comply with the requirements of §353 of the Public Health Service Act (the Clinical Laboratory Improvement Amendments (CLIA) of 1988. Pub. L. 100-578).

2) X-ray services provided by an x-ray vendor in compliance with 42 CFR §§ ~~§§~~486.100 to 486.110.

3) X-ray services provided by or at the request of a chiropractor are covered only when necessary to support a diagnosis of subluxation of the spine.

4.a. Nursing facility services for individuals age 21 or older (other than services in an institution for mental diseases):

- Residents must have their level of care certified by a physician, and must be determined by a long-term care consultation team to require the level of care provided in a nursing facility, prior to admission.

- Reserved-bed services are provided as indicated in Attachment 4.19-C.

- All medical equipment needed to provide routine services to residents must be supplied. Medical equipment that is not covered in the per diem rate, for which the need is identified and documented in the recipient's plan of care, and that is necessary for the continuous care and exclusive use of the recipient to meet an unusual medical need, can be separately reimbursed.

- Prior to admission to a nursing facility, all applicants must be screened and have a Level I identification screen to determine possible mental illness or mental retardation.

- If an individual with mental illness or mental retardation is admitted to a nursing facility without being screened and having a Level II evaluation and does not meet the exemptions for certain hospital discharges, the person must be screened before Medical Assistance will reimburse the facility.

- Influenza and pneumococcal immunizations for adults are an exception to the requirement that physicians must sign and date all orders. If there is a standing order for these immunizations, they may be administered by licensed health care professionals trained to: 1) screen residents for contraindications to vaccination; 2) administer vaccines; and 3) monitor residents for adverse events, in accordance with state and local regulations. Administration of immunizations pursuant to a standing order must be according to facility policy developed in consultation with a physician.

4.b.Early and periodic screening, diagnosis, and treatment services:

- Early and periodic screening, diagnosis and treatment service is a service provided to a recipient under age 21 to detect, prevent, and correct physical and mental conditions or illnesses discovered by screening services, and to provide diagnosis and treatment for a condition identified according to 42 CFR 441.50 and according to section 1905(r) of the Social Security Act.
- Initial and periodic screenings are provided as indicated by the periodicity schedule. Inter-periodic screens are available to recipients based on medical necessity. An EPSDT service can be requested by the recipient or performed by a provider at any time if medically necessary.
- Initial face-to-face and written notifications of recipients are followed up by county agencies with telephone contacts, letters, and/or home visits. Annual or periodic written notifications may also be supplemented by personal contacts.
- Drugs that are considered investigational, drugs that are provided to a recipient during the clinical trial designed to test the efficacy of the provided drug, or drugs that have not been approved for general use by the U.S. Food and Drug Administration are not covered.

A diagnostic assessment is a written report that documents clinical and functional face-to-face evaluation of a recipient's mental health, including the nature, s[1]everity and impact of behavioral difficulties, functional impairment, and subjective distress of the recipient, and identifies the recipient's strengths and resources. A diagnostic assessment is necessary to determine a recipient's eligibility for mental health services.

~~An interactive diagnostic assessment, usually performed with children, may use physical aids and nonverbal communication to overcome communication barriers because the recipient demonstrates one of the following:~~

- ~~Has lost or has not yet developed either the expressive language communication skills to explain his/her symptoms and response to treatment~~
- ~~Does not possess the receptive communication skills needed to understand the mental health professional if he/she were to use adult language for communication or~~
- ~~Needs an interpreter, whether due to hearing impairment or the recipient's language is not the same as the provider's, in order to participate in the diagnostic assessment~~

Brief Diagnostic Assessment

The Brief Diagnostic Assessment includes a written clinical summary that explains the diagnostic hypothesis which may be used to address the recipient's immediate needs or presenting problem. The assessment collects sufficient information to apply a provisional clinical hypothesis. A brief diagnostic must not be used for a child under six years of age. Components includes:

- ~~The recipient's current life situation~~ Age
- Recipient's description of symptoms (including reason for referral)
- History of mental health treatment
- Cultural influences on the client, and
- A mental status exam
- ~~Screenings used to determine a recipient's substance use, abuse, or dependency, and other standardized screening instruments~~

Standard Diagnostic Assessment

- All components of Brief Diagnostic assessment, the client's: current living situation, status of basic needs, education level, employment status, current medications, immediate risks to health and safety, and perceptions of their own condition.
- Screenings used to determine a recipient's substance use, abuse, or dependency
- Conducted in the cultural context of the recipient
- An assessment of the recipient's needs based on baseline measurements, symptoms,behavior, skills, abilities, resources, vulnerabilities, and safety
- Assessment methods and use of standardized assessment tools ~~Clinical summary~~ diagnostic formulation, recommendations, and prioritization of needed mental health, ancillary or otherservices

4.b. Early and periodic screening, diagnosis, and treatment services, continued:

- Involvement of the recipient and recipient's family in assessment and service preferences and referrals to services
- Sufficient recipient data to support findings on all axes of the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)or the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, and any differential diagnosis

~~**Extended Diagnostic Assessment**~~

- ~~All requirements of a Standard Diagnostic Assessment, which are gathered over three or more appointments due to the recipient's complex needs that necessitate significant additional assessment time.~~
- ~~Complex needs are those caused by:~~
  - ~~o Acuity of psychotic disorder~~
  - ~~o Cognitive or neurocognitive impairment~~
  - ~~o A need to consider past diagnoses and determine their current applicability~~
  - ~~o Co-occurring substance abuse use disorder~~
  - ~~o Disruptive or changing environments,~~
  - ~~o Communication barriers~~
  - ~~o Cultural considerations~~

~~An adult diagnostic assessment update can only be an update of a standard or extended diagnostic assessment for individuals age 18 and older. It updates the most recent diagnostic assessment. The update:~~

- ~~Reviews recipient's life situation: updates significant new or changed information, documents where there has not been significant change~~
- ~~Screens for substance use, abuse, or dependency~~
- ~~Mental status exam~~
- ~~Assesses recipient's needs based on baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, safety needs~~
- ~~Includes a clinical summary~~
- ~~Includes recommendations and prioritization of needed mental health, ancillary, or other services~~
- ~~Includes involvement of recipient and recipient's family in assessment and service preferences and referrals to services~~
- ~~Includes diagnosis on all axes of the current edition of the DSM~~

The following are in excess of Federal requirements:

- Screened recipients receive a written copy of any abnormal screening findings.

The following health care not otherwise covered under the State Plan is covered for children by virtue of the EPSDT provisions of Title **XIX:**

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

1. **Children's therapeutic services and supports** for children is a package of mental health services for children that includes varying levels of therapeutic and rehabilitative intervention provided by mental health professionals, clinical trainees, and mental health practitioners, mental health certified family peer specialists, and mental health behavioral aides under the clinical supervision of mental health professionals, in order to treat a diagnosed emotional disturbance or mental illness. The interventions are delivered using various treatment modalities and combinations of services designed to realize treatment outcomes identified in a recipient's individual treatment plan. Treatment staff who are not mental health professionals receive treatment supervision from a mental health professional.

A diagnostic assessment by a mental health professional or ~~mental health practitioner~~ clinical trainee as described in item 6.d.A, must have determined that the child is in need of children's therapeutic services and supports to address an identified disability and functional impairment. A child may be determined to be eligible for up to five days of children's therapeutic services and supports day treatment, based on a hospital's medical history and presentation examination of the child.

Qualified children's therapeutic services and supports providers can provide diagnostic assessment, explanation of findings, psychological testing and neuropsychological services.

The following are eligible to provide children's therapeutic services and supports:

A. A county-operated or non-county operated entity certified by theDepartment
B. A facility of the Indian Health Service or a facility owned or operated by a tribe or tribal organization and funded by either Title I of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, P.L. 106-260, operating as a 638 facility. A facility ofthe Indian Health Service or a 638 facility must be certified by the Department.

Provider Qualifications and Training

A. A mental health professional is an individual defined in item 6.d.A.

B. A mental health practitioner working under the direction of a mental health professional:

1) holds a bachelor's degree in one of the behavior sciences or related fields from an accredited college or university, works in a day treatment program, and:

a. has at least 2,000 hours of supervised experience in the deliveryof mental health services to children with emotional disturbances~~,~~or mental illness;

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

b) is fluent in the non-English language of the ethnic group to which at least 50 percent of the practitioner's clientsbelong, completes 40 hours of training in the delivery of services to clients with mental illness or emotional disturbance~~s~~, and receives clinical supervision from a mental health professional at least once a week until the requirement of 2,000 hours of supervised experience is met; or
c) receives 40 hours of training in the delivery of services to clients with mentalillness or emotional disturbance within the first six months of employment, and receives weekly supervision from a mental health professional until he or she has 2,000 hours of supervised experience. Or,

2) has at least 4,000 hours of supervised experience in the delivery of services to children with emotional disturbances, mental illness, or substance use disorder, including hours worked as a mental health behavioral aide I or II; a practitioner with 2,000 hours of supervised experience must receive weekly supervision from a mental health professional until he or she has 4,000 hours of supervised experience; or
3) has at least 4,000 hours of supervised experience in the delivery of services to children with traumatic brain injury or developmental disabilities, and completes Department required training on mental illness and emotional disturbance. A practitioner with 2,000 hours of supervised experience must receive weekly supervision from a mental health professional until he or she has 4,000 hours of supervised experience; or
4) is a graduate or undergraduate student in one of the behavioral sciences or related fields and is formally assigned by an accredited college or university to an agency or facility for clinical training; or
5) holds a master's or other graduate degree in one of the behavioral sciences or related fields from an accredited college or university; or
6) holds a bachelor's degree in one of the behavioral sciences or related fields, and completes a practicum or internship that requires direct interaction with children and is focused on behavioral sciences or a related field; or

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

~~7) is working as a clinical trainee as described in item 6.d.A.~~

C. A mental health behavioral aide, a paraprofessional who is not the legal guardian or foster parent of the child, working under the direction of a mental health professional or a mental health practitioner under the clinical supervision of a mental health professional.

1) Level I mental health behavioral aides must:

a. be at least 18 years of age; and

~~b.~~ have a high school diploma or general equivalency diploma (GED) or two years of experience as a primary caregiver to a child with severe emotional disturbance or mental illnesswithin the previous ten years; and

~~c. meet the following orientation and training requirements:~~

~~i. 30 hours of preservice training covering Minnesota's data privacy law; the provisions of Minnesota's Comprehensive Children's Mental Health Act; the different diagnostic classifications of emotional disturbance; the use of psychotropic medications in children and the potential side effects; the core values and principles of the Child Adolescent Service System Program; how to coordinate services between the public education system and the mental health system; how to provide culturally appropriate services; and how to provide services to children with developmental disabilities or other special needs.~~

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

Fifteen hours must be face-to-face training in mental health services delivery and eight hours must be parent team training, which includes partnering with parents; fundamentals of family support; fundamentals of policy' and decision-making; defining equal partnership; complexities of parent and service provider partnership in multiple service delivery systems; sibling impacts; support networks; and community resources; and 20 hours of continuing education every two calendar years. Topics covered are those identified in subclause i., above.

1) a Level II mental health behavioral aide must:

1) be at least 18 years of age;
2) have an associate or bachelor's degree or 4,000 hours of experience delivering clinical services to children with in the treatment of mental illness or emotional disturbance concerning children or adolescents, or complete a certification program approved by the Department; and
3) meet the preservice and continuing education requirements as a Level I mental health behavioral aide.

B. A day treatment multidisciplinary team that includes at least one mental health professional ~~and one mental health practitioner~~.

Components of Children's Therapeutic Services and Supports

Persons providing children's therapeutic services and support must be capable of providing the following components:

A. Psychotherapy: patient and/or family, family, and group. Family psychotherapy services must be directed exclusively to the treatment of the child. ~~Psychotherapy services require prior authorization.~~

B. Individual, family, or group skills training designed to facilitate the acquisition of psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory that was disrupted by psychiatric illness.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

~~Fifteen hours must be face-to-face training in mental health services delivery and eight hours must be parent team training, which includes partnering with parents; fundamentals of family support; fundamentals of policy' and decision-making; defining equal partnership; complexities of parent and service provider partnership in multiple service delivery systems; sibling impacts; support networks; and community resources; and~~

~~i. 20 hours of continuing education every two calendar years. Topics covered are those identified in subclause i., above.~~

2) a Level II mental health behavioral aide must:

1) be at least 18 years of age;
2) have an associate or bachelor's degree ~~or 4,000 hours of experience delivering clinical services to children with in the treatment of mental illness or emotional disturbance concerning children or adolescents,~~ or complete a certification program approved by the Department; and
~~3) meet the preservice and continuing education requirements as a Level I mental health behavioral aide.~~

D. A day treatment multidisciplinary team that includes at least one mental health professional and one mental health practitioner.
E. A clinical trainee

A clinical trainee, mental health practitioner, certified family peer specialist, or mental heath behavioral aide must have at least 30 hours of continuing education every two years, as described by state law.

A clinical trainee, mental health practitioner, certified family peer specialist, or mental heath behavioral aide must perform all services described under the supervision of a mental health professional and have a written treatment supervision plan, developed within 30 days of employment and updated annually.

Each staff person's treatment supervision plan must include:

(1) the name and qualifications of the staff person receiving treatment supervision;

(2) the names and licensures of the treatment supervisors who are supervising the staff person;

(3) how frequently the treatment supervisors must provide treatment supervision to the staff person; and

(4) the staff person's authorized scope of practice, including a description of the client population that the staff person serves, and a description of the treatment methods and modalities that the staff person may use to provide services to clients.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

Components of Children's Therapeutic Services and Supports

Persons providing children's therapeutic services and support must be capable of providing the following components:

A. Psychotherapy: patient and/or family, family, and group. Family psychotherapy services must be directed exclusively to the treatment of the child. Psychotherapy services require prior authorization.

B. Individual, family, or group skills training designed to facilitate the acquisition of psychosocial skills that are medically necessary to rehabilitate the child to an age- appropriate developmental trajectory that was disrupted by psychiatric illness.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

Crisis planning. Crisis planning services focus on crisis identification and prevention and is 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 coping mechanisms, or the presentation of danger to self or others. The services help the child, the child's family and all providers of services to the child to:

1) recognize factors precipitating a mental health crisis;
2) identify behaviors related to the crisis; and
3) be informed of available resources to resolve the crisis.

Crisis planning services must be coordinated with emergency services. Emergency services must be available 24 hours per day, seven days a week;

C. Mental health behavioral aide services means medically necessary one- on-one activities performed by a trained paraprofessional to practice psychosocial skills and assist a child retain or generalize psychosocial skills according to the child's treatment plan that a mental health professional, clinical trainee, or mental health practitioner has previously taught to the child according to the child's treatment plan.

supersedes:22-08, (15-03,14-16, 13-14, 09-22, 06-12, 04-10, 02-22)

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

C. direction of a mental health behavioral aide by a mental health professional, a clinical trainee, ~~who assumes full professional responsibility,~~ or ~~direction of a mental health behavioral aide by~~ a mental health practitioner working under the clinical supervision of a mental health professional ~~who assumes full professional responsibility~~. Direction is based on the child's individualized treatment plan and means to ensure performance of activities in guiding the mental health behavioral aide in providing services to a client and to continuously evaluate the mental health behavioral aide's ability to carry out the MHBA activities in the individualized treatment plan.~~:~~

~~1) ongoing, on-site observation by a mental health professional or mental health practitioner for at least one hour during every 40 hours of service ; and~~

~~2) immediate accessibility of the mental health professional or mental health practitioner to the mental health behavioral aide when the services are provided.~~

D. mental health service plan development includes the development, review, and revision of a child's individual treatment plan;

~~E. Functional assessment. A functional assessment is the administration and reporting of standardized outcome measurement instruments.~~

Components A-B, above, may be combined to constitute a mental health day treatment program, provided by a multidisciplinary staff under the clinical supervision of a mental health professional. A day treatment program consists of psychotherapy for three or more recipients and individual or group skills training. It is provided by an outpatient hospital accredited by the Joint Commission on the Accreditation of Healthcare Organizations, a community mental health center, or a county contracted day treatment provider. ~~Day treatment is provided at least one day a week for a minimum two-hour time block (of which one hour, is individual or group psychotherapy), but no more than three hours per day.~~ A child may receive less than two hours per day of day treatment if the child is transitioning in or out of day treatment.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

The services specified in items A through F below are **not** eligible for Medical Assistance payment:

A. Service components of children's therapeutic services and supports simultaneously provided by more than one provider entity.

B. Children's therapeutic services and supports not provided by Minnesota's Medicaid program.

C. 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.

D. Services that are the responsibility of a residential or program license holder, including foster care providers.

E. More than 15 hours of children's therapeutic services and supports provided within a six-month period to a child with severe emotional disturbance who is residing in a hospital, ~~a group home,~~ a residential treatment facility, psychiatric residential treatment facility, or other institutional group setting or who is participating in a partial hospitalization program, if part of a discharge plan.

F. Simultaneous treatment of an individual recipient by multiple mental health professionals, multiple mental health practitioners, or multiple behavioral aides for the same purpose.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

~~**Telemedicine services.** Children's therapeutic services and supports that are otherwise covered as direct face-to-face services may be provided via two-way, interactive video if medically appropriate to the condition and needs of the recipient.~~

2. **Crisis response services** for children are services recommended by a physician, mental health professional or clinical trainee as defined ~~for children's therapeutic services and support~~ in 6.a, or a mental health practitioner as defined for **children's therapeutic services and supports.** For purposes of item 4.b., a child eligible for crisis response servicesmeans a child under age 21 who:

   A. is screened as possibly experiencing a mental health crisis where a crisis assessment is needed; and
   B. is assessed as experiencing a mental health crisis and mobile crisis intervention or crisis stabilization services are necessary.

The following are eligible to provide crisis response services:

A. An entity operated by a county.

B. An entity under contract with a county.

C. A facility of the Indian Health Service or a facility owned or operated by a tribe or tribal organization and funded by either Title I of the Indian Self-Determination and EducationAssistance Act, P.L. 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, P.L. 106-260, operating as a 638 facility.

Training and provider standards

A crisis provider must have at least one mental health professional on staff at all times and at least one additional staff member capable of leading a crisis response in the community.Members of the team provide only those crisis services that arewithin their scope of practice, and under the supervision required by state law.

Crisis assessment and intervention must be available 24 hours a day, seven days a week. However, if a county provider demonstrates to the satisfaction of the Department that, due to geographic or other barriers, it cannot provide services 24 hours a day, seven days a week, the Department may approve a county provider based on an alternative plan proposed by a county or groups of counties. The alternative plan must be designed to 1)result in increased access and reduction in disparities in the availability of crisis services; and 2)provide mobile services outside of normal business hours and on weekends and holidays.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

Components of Crisis Response Services

Persons providing crisis response services must be capable of providing the following components:

A. Crisis assessment. Crisis assessment is an immediate face-to-face assessment by a physician, mental health professional, clinical trainee, or mental health practitioner under the ~~clinical~~ supervision of a mental health professional, following a screening that suggests the child may be experiencing a mental health crisis or mental health emergency.

The crisis assessment is an evaluation of any immediate needs for which emergency services are necessary and, as time permits, the recipient's life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning. ~~Crisis assessment services must be available 24 hours a day, seven days a week. However, if a county provider demonstrates to the satisfaction of the Department that, due to geographic or other barriers, it cannot provide crisis assessment 24 hours a day, seven days a week, the Department may approve a county provider based on an alternative plan proposed by a county or groups of counties. The alternative plan must be designed to 1)result in increased access and reduction in disparities in the availability of crisis services; and 2)provide mobile services outside of normal business hours and on weekends and holidays.~~

B. Crisis intervention. Crisis intervention is a face-to-~~fact~~face, short- term intensive mental health service provided during a mental health crisis or mental health emergency to help a recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning. Crisis intervention must be provided on-site by a mobile crisis intervention team ~~outside of an emergency room, urgent care, or inpatient hospital setting~~. Services delivered to a beneficiary while admitted to an inpatient hospital are excluded from coverage under this section ~~Crisis intervention must be available 24 hours a day, seven days a week. However, if a county provider demonstrates to the satisfaction of the Department that, due to geographic or other barriers, it cannot provide crisis intervention 24 hours a day, seven days a week, the Department may approve a county provider based on an alternative plan proposed by a county or groups of counties. The alternative plan must be designed to 1)result in increased access and reduction in disparities in the availability of crisis services; and 2)provide mobile services outside of normal business hours and on weekends and holidays.~~

2) Crisis intervention is provided after the crisis assessment.

Crisis intervention includes developing an initial,

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

brief crisis treatment plan not later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of servic s to be provided. The plan must be updated as needed to reflect current goals and services.

The crisis intervention team must document which short-term goals were met, and when no further crisis intervention services are required.

~~1) The crisis intervention team is comprised of at least two mental health professionals, or a combination of at least one mental health professional and one mental health practitioner with the required crisis training and under the clinical supervision of a mental health professional on the team. The team must have at least two members, with at least one member providing on-site crisis intervention services when needed.~~

2) If possible, .at least two members of the crisis intervention team must confer in person or **by** telephone about the assessment, crisis treatment plan, and necessary actions taken.

~~3) If crisis intervention services continue into a second calendar day, a mental health professional must contact the client face-to-face on the second day to provide services and update the crisis treatment plan.~~

4) If the recipient's crisis is stabilized, but the recipient's needs a referral for mental health crisis stabilization or other services, the team must provide referrals to these services.

5) If crisis stabilization is necessary, the crisis intervention team must complete the individual treatment plan recommending crisis stabilization. If there is an inpatient ~~or urgent care visits~~visit, the plan is completed by staff of the facility.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

C. Crisis stabilization. Crisis stabilization is an individualized mental health service designed to restore a recipient to the recipient's prior functional level.

1) Crisis stabilization cannot be provided without first providing crisis intervention.

2) Crisis stabilization is provided by a mental health professional or a mental health practitioner working under the clinical supervision of a mental health professional and for a crisis stabilization services provider. Mental health practitioners must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

3) Crisis stabilization may be provided in a recipient's home, another community setting, or a supervised licensed residential programs that is not an IMD that provides short-term services if the service is not included in the facility's reimbursement.

4) A crisis stabilization treatment plan must be developed, and services must be delivered according to the plan. If clinically appropriate, the recipient must participate in the development of the plan. The plan must be completed within 24 hours of beginning services and developed by a mental health professional or a mental health practitioner under the clinical supervision of a mental health professional. At a minimum, the plan must contain:

a) a list of problems identified in the assessment;

b) a list of the recipient's strengths and resources:

c) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement of the goals;

d) specific objectives directed toward the achievement of each goal;

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

e) documentation of the participants involved in the service planning;

f) planned frequency and type of services initiated;

g) the crisis response action plan should a crisis occur; and

h) clear progress noted on the outcome of the goals.

~~**Telemedicine services.** Crisis response services for children that are otherwise covered as direct face-to-face services may be provided via two-way, interactive video if medically appropriate to the condition and needs of the recipient.~~

The services specified in items A through I below are **not** eligible for Medical Assistance payment:

A. Recipient transportation services.
B. Services provided by a nonenrolled Medical Assistance provider.
C. Room and board.
D. Services provided to a recipient admitted to an inpatient hospital.
E. Services provided by volunteers.
F. Direct billing of time spent "on call" when not providing services.
G. Provider service time paid as part of case management services.
H. Outreach services, which are services identifying potentially eligible people in the community, informing potentially eligible people of the availability of mental health crisis response services, and assisting potentially eligible people with applying for these services.
I. A mental health service that is not medically necessary.

Pages 17n through 17nn are intentionally omitted.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

~~I. A mental health service that is not medically necessary.~~

3. **Services provided to recipients with severe emotional disturbance residing in a children's residential treatment facility** are provided by a county-operated or non-county operated entity, under contract with the county or a tribally operated entity and are limited to:

A. Intake, treatment planning and support. This includes developing, monitoring and revising the treatment plan, recording the recipient's medical history, providing a basic health screening and referring for health services if necessary, assisting in implementing health regimes, medication administration and monitoring, coordinating home visits when consistent with treatment plan goals, coordinating discharge and referral for aftercare services, and travel and paperwork related to intake, treatment planning and support.

B. Psychological examinations, case consultation, individual and group psychotherapy, and counseling. includes testing necessary to make these assessments.

C. Skills ~~development~~training. This means therapeutic activities designed to restore developmentally appropriate functioning in social, recreational, and daily living skills. It includes structured individual and group skills building activities.

It also includes observing the recipient at play and in social situations, and performing daily living activities and engaging in on-the-spot intervention and redirection of the recipient's behavior consistent with treatment goals and age-appropriate functioning.

D. Family psychotherapy and skills training designed to improve the basic functioning of the recipient and the recipient's family in the activities of daily and community living, and to improve the social functioning of the recipient and the recipient's family in areas important to the recipient's maintaining or reestablishing residency in the community. This includes assessing the recipient's behavior and the family's behavior to the recipient, activities to assist the family in improving its understanding of normal child

4.b. Early and periodic screening, diagnosis, and treatment services. (continued)

development and use of parenting skills to help the recipient achieve the goals of the treatment plan, and promoting family preservation and unification, community integration, and reduced use of unnecessary out-of-home placement or institutionalization. Family psychotherapy and skills training is directed exclusively to treatment of the recipient.

Covered services are:

1. Provided pursuant to an individual treatment plan based on recipients' clinical needs;

2. Developed with assistance from recipients' families or legal representatives; and

3. Supervised by a mental health professional who provides ~~at least weekly face-to-face~~ supervision either individually or as a group to staff providing program services to a resident.

Provider Qualifications and Training

Members of the multidisciplinary team provide residential rehabilitative services within their scope of practice under the supervision of a mental health professional as defined in item 6.d.A.

4.b. Early and periodic screening, diagnosis, and treatment services. (continued)

4. **Personal care assistant services identified in an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) under the Individuals with Disabilities Education Act (IDEA)** and provided by school districts to children during the school day.

The services must meet all the requirements otherwise applicable under item 26 of this Attachment if the service had been provided by a qualified, enrolled provider other than a school district, with the following exceptions:

A. a personal care assistant need not be an employee of a personal care provider organization;

B. assessments, reassessments and service updates are not required;

C. Department prior authorization is not required;

D. a personal care assistant provides services under the direction of a qualified professional which includes registered nurses, public health nurses, licensed school nurses, mental health professionals, physical therapists, occupational therapists, speech language pathologists, audiologists or physicians, as designated in the IEP;

E. PCA Choice is not an option.

To use an authorized home care personal care assistant at school, the recipient or responsible party must provide written authorization in the recipient's care plan identifying the chosen provider and the daily amount of services to be used at school.

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

5. **Youth Assertive Community Treatment (Youth ACT)** is intensive nonresidential rehabilitative mental health services recommended by a mental health professional defined in item 6.d.A. after a diagnostic assessment and a level-of-care determination, using an instrument approved by the Department, which indicates a need for intensive integrated intervention without 24-hour medical monitoring and a need for extensive collaboration among multiple providers.

   Recipients must be diagnosed with a serious mental illness or co-occurring substance abuse addiction. Additionally, recipients must have either a:

   A. Functional impairment, and
      1) a history of difficulty in functioning safely and successfully in the community, school, home, or job; or
      2) be likely to need future services from the adult mental health system; or
   B. Recent diagnostic assessment that documents that intensive nonresidential rehabilitative mental health services are medically necessary to ameliorate identified symptoms and functional impairments and to achieve individual transition goals.

   The following are eligible to provide youth ACT services:

   A. An entity contracting with the Department.
   B. A facility of the Indian Health Service or a facility owned or operated by a tribe or tribal organization and funded by either Title I of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, P.L. 106-260, operating as a 638 facility.

STATE: MINNESOTA
Effective: September 15, 2022
TN: 22-24
Approved:9/14/2022
Supersedes: 17-21, 13-14, 12-13

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

Provider Qualifications, Training and Supervision

Youth ACT services are provided by a multidisciplinary staff using a total team approach and assertive outreach for treatment in a recipient's environment. The team includes a clinical supervisor who is a mental health professional as defined in item 6.d.A and other staff consistent with the Minnesota Youth ACT treatment standards, which will be published by the Department and available on the Department's website at www.dhs.state.mn.us.

The multidisciplinary team must include:

A. A mental health professional as defined in item 6.d.A.

B. A mental health practitioner as defined in item 4.b.

C. A mental health case manager as defined in item E.1. of Supplement 1 to Attachment 3.1-A.

D. A certified peer support specialist who~~:~~ meets the definition in 3.d.3 and is also a former children's mental health consumer.

~~a. Must be at least 22 years of age;~~

~~b. Has a high school diploma or equivalent;~~

~~c. Has had a diagnosis or mental illness, or co-occurring mental illness and substance abuse addiction and is willing to disclose that history to team members and clients;~~

~~d. Must be a former consumer of child mental health services, or a former or current consumer of adult mental health services, for a period of at least two years.~~

~~e. Successfully completed peer specialist certification training that includes specific skills relevant to providing peer support to other consumers, parent-teaming training, and training specific to child development.~~

~~f. Must complete 30 hours of relevant continuing education each calendar year in topics such as children's mental and physical health, educational development, and culture.~~

E. A clinical trainee, as defined in item 6.d.A

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

The team must provide the following:

A. individual, family and group psychotherapy;
B. individual, family and group skills training;
C. crisis ~~assistance~~ planning;
D. medication management;
E. mental health case management;
F. medication education services;
G. care coordination;
H. psychoeducation of and consultation and coordination with theclient's biological, adoptive, or foster family; in the case of a youth living independently, the client's immediate non- familial support network;
I. clinical consultation to a recipient's employer, school, othersocial service agencies, housing providers, and to the courts to assist in managing the mental illness or co-occurring disorder and to develop client support systems;
J. coordination with, or performance of, crisis intervention andstabilization services;
K. assessment of a client's treatment progress and effectivenessof services using standardized outcome measures published by the Department;
L. transition services;
M. co-occurring substance use disorder ~~integrated dual disorders~~ treatment;
N. peer support services;
O. housing access support.

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

The services below are not eligible for medical assistance payment as youth ACT services:

A. recipient transportation services otherwise paid under this Attachment;
B. services billed by a non-enrolled Medicaid provider;
C. services provided by volunteers;
D. direct billing of days spent "on call" when not providing services;
E. job-specific skills services, such as on-the-job training;
F. performance of household tasks, chores, or related activities for the recipient;
G. outreach services, as defined for adult rehabilitative mental health services on page 53g;
H. inpatient psychiatric hospital treatment;
I. mental health residential treatment;
J. partial hospitalization;
K. physician services outside of care provided by a psychiatrist serving as a member of the treatment team;
L. room and board costs;
M. children's mental health day treatment services;
N. mental health behavioral aid services.

1. **Child and Family Psychoeducation Services** provide information or demonstration to an individual or family as part of an individual, family, multifamily group, or peer group session. Family psychoeducation services explain, educate, and support the child and family in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development. Services are provided so that the individual, family, or group can help the child prevent relapse and the acquisition of comorbid disorders, while achieving optimal mental health and long-term resilience. Child and f~~F~~amily psychoeducation services are provided by a mental health professional, ~~or a mental health practitioner working as~~ a clinical trainee, or a mental health practitioner as defined in Item 6.d.A.

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

5. In-reach Care Coordination services, as described in items 5.a. and 6.d.A., and provided to children with a serious emotional disturbance who have frequented a hospital emergency room two or more times in the previous consecutive three months, or been admitted to an inpatient psychiatric unit two or more times in the previous consecutive four months, or is being discharged from eitherfacility to a shelter.

6. Mental Health Clinical Care Consultations are communications from a treating mental health professional, or treating ~~mental health practitioner working as a~~ clinical trainee, as defined in Item 6.d.A., to other providers or educators not under the ~~clinical~~ supervision of the treating mental health professional who are working with the same recipient. Recipients have been diagnosed witha complex mental health condition or a mental health condition that co-occurs with other complex and chronic conditions. The communications inform, inquire, and instruct regarding the client's symptoms; provide strategies for effective engagement, care, and intervention needs; describe treatment expectations across service settings; and direct and coordinate clinical service components provided to the client and family.

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

7.Certified Family Peer Specialists provide services within an existing mental health community provider setting to recipients diagnosed with emotional disturbance, or severe emotional disturbance. Services may be provided to the child's parents or legal guardians if those services are directed exclusively toward the benefit of the child.

Provider Qualifications and Training: a certified family peer specialist

A. Be at least 18~~21~~ years of age;
B. Have a high school degree or its equivalent,
C. Have raised, or are currently raising a child with a mental illness;
D. Have experience navigating the children's mental health system;
E. Successfully complete peer specialist certification training approved by the Department that teaches participating consumers specific skills relevant to providing peer support to other parents.

Components of Family Peer Specialist Services

Certified family peer specialists provide the following services that are recommended by a mental health professional, as defined in item 6.d.A, or a physician:

A. nonclinical family peer support counseling;
B. collaboration with other care providers;
C. non-adversarial advocacy;
D. promotion of the individual family culture in the milieu;
E. initiation of interaction amongst parents in the community;
F. support and guidance to promote resiliency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services;
G. education to parents in developing coping mechanisms, problem- solving skills, availability of community resources, and mental illness in general; and
H. establishment of peer led parent support groups;

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

10. **Early Intensive Developmental and Behavioral Intervention (EIDBI).** EIDBI services are medically necessary intensive treatment provided to promote the child's optimal independence and participation in family, school and community life; EIDBI services educate and support families, reduce stress, and improve long-term outcomes and quality of life for children and their families.

EIDBI provides a range of individualized, medically necessary intensive developmental and behavioral interventions to address or treat, in a comprehensive manner, the functional skills and core deficits of autism spectrum disorder (ASD) and other related conditions that cause persistent, clinically significant impairment in social communication and behavioral interaction and other areas of functional development for which this service is medically appropriate. Skill development focuses on the following domains: self-regulation, self-care, behavioral challenges, expressive communication, receptive communication, cognitive functioning, and safety. ~~social/interpersonal interactions, verbal and non-verbal communication, cognition, learning and play, adaptive, self-help skills, and behavioral self-regulation~~.

Services must be provided directly to the child.~~, or on behalf of the child, by~~ Family/caregiver training may be provided to the child's parents/caregivers for the benefit of the child.

A **comprehensive multi-disciplinary evaluation (CMDE)** must be completed to determine medical necessity of EIDBI services. The CMDE must include:

- Assessment of the child's degree of severity of core features of ASD and related conditions, as well as other areas of functional development including, self-regulation, self-care, behavioral challenges, expressive communication, receptive communication, cognitive functioning, and safety ~~cognition, learning and play, social/personal interaction, verbal and non-verbal communication, adaptive, self-help, behavioral self-regulation, and motor development~~;
- Review and incorporation of the diagnosis and other related assessment information from other qualified professionals, including information gathered from family members, child care providers, as well as any medical or assessment information from other licensed professionals working with the child such as the child's rehabilitation therapists, licensed school personnel, or other mental health professionals;

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

- Identification of parent/caregiver preferences and familyculture, language, goals and values; and
- Assessment of the type and level of parent/caregiver trainingand involvement preferred.

Qualified CMDE Provider: A licensed mental health professional, as described in item 6.d.A of Attachments 3.1-A and 3.1-B, ~~a mental health practitioner working as~~ a clinical trainee and under the supervision of a psychiatrist or mental health professional, or a physician is qualified to provide the CMDE. Providers must:

A. Have at least 2,000 hours of clinical experience in the evaluation and treatment of children with ASD or a related condition, or equivalent documented course-work at the graduate level by an accredited university in the following content areas: ASD diagnosis and treatment strategies related to ASD and related conditions, and child development;
B. Be able to diagnose and/or provide treatment; and
C. Work within their scope of practice and professional license.

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

Provider Qualifications and Training.

Qualified Supervising Professional: All EIDBI services must be billed by, and either provided by or under the clinical supervision of a qualified supervising professional who assumes full professional responsibility for the services provided by Level I, II and III EIDBI providers. A qualified supervising professional is a mental health professional, as described in item 6.d.A, or a Licensed Board-Certified Behavior Analyst.

Qualified supervising professionals must work within their licensed scope of practice, and have at least 2,000 hours of supervised, clinical experience and/or training in the examination and/or treatment of children with ASD or a related condition, or equivalent documented coursework at the graduate level by an accredited university in the areas of ASD diagnostics, ASD developmental and behavioral treatment strategies and typical child development.

The following non-licensed practitioners are qualified to provide EIDBI treatment when services are provided for the direct benefit of the child, supervised directly and within the scope of practice of the qualified supervising professional who assumes full professional responsibility for these activities, and they are billed by a qualified supervising professional as described below:

A. **Level I EIDBI provider:**

All Level I providers must be employed by an EIDBI agency and meet at least one of the following standards:

1. Have both of the following:
   a. At least 2,000 hours of supervised, clinical experience and/or training in the examination and/or treatment of children with ASD or a related condition, or equivalent documented coursework at the graduate level by an accredited university in the areas of ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development, or an equivalent combination of documented coursework and hours of experience. Providers without the required hours of supervision must receive observation and direction from a qualified supervising professional at least once per month until he or she has 2,000 hours of supervised clinical experience; and

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

~~Additionally, all Level I providers must:~~

b. ~~Have~~ A ~~a~~ master's degree, or be enrolled in a master's program, in one of the behavioral health, child development or allied fields (such as, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy) from an accredited college or university.; or ~~Providers without the required hours of supervision must receive observation and direction from a qualified supervising professional at least once per month until he or she has 2,000 hours of supervised clinical experience;~~

2. Have a bachelor's degree in one of the behavioral health, child development or allied fields (such as, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy) from an accredited college or university and advanced certification in one of the OHS recognized treatment modalities; or
3. Be a board certified behavior analyst (BCBA); or
4. Be a board certified assistant behavior analyst (BCaBA) and 4,000 hours of supervised, clinical experience that meets all registration, supervision, and continuing education requirements of the certification~~.~~; or
5. Have at least 6,000 hours of clinical experience providing early intervention services in the modality the EIDBI agency uses, and have a Bachelor's Degree in a related field, and completed the EIDBI level III provider training requirements.

B. **Level II EIDBI provider:**

All Level II providers must be employed by an EIDBI agency and meet one of the following standards:

1. Have a bachelor's degree in one of the behavioral or child development sciences or allied fields (such as, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy) from an accredited college or university; and meet one of the following requirements:
   - a. have at least 1,000 hours of supervised, clinical experience and/or training in the examination and/or treatment of children with ASD or a related condition~~.~~; or
   - b. equivalent documented coursework at the graduate level by an accredited university in the areas of ASD diagnostics, ASD developmental and behavioral treatment strategies and typical child development~~.~~; or
   - c. an equivalent combination of documented coursework and hours of experience; or
   - d. a board-certified assistant behavior analyst (BCaBA); or
   - e. a registered behavior technician (RBT); or
   - f. certified in one of the other treatment modalities recognized by the Department.

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

2. Be age 18 or older, have completed initial certification in the modality provided by the agency employer, have completed the EIDBI level III provider training requirements, and receive observation and direction from the advanced certification provider at least once per week until meeting 1,000 hours of supervised clinical experience; or

3. Be currently enrolled in a bachelor's degree program in one of the behavioral or child development sciences or allied fields (such as, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy) from an accredited college or university, and receive observation and direction from a qualified supervising professional or Level I treatment provider at least twice per month until meetings 1,000 hours of supervised clinical experience~~.~~; or

4. Have an associate's degree in one of the behavioral or child development sciences or allied fields (such as, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy) from an accredited college or university, and at least 2,000 hours of supervised, clinical experience in delivering treatment to children with ASD or a related condition. Hours worked as a mental health behavioral aide or Level III provider may be included in the required hours of experience~~.~~; or

5. Have at least 4,000 hours of supervised, clinical experience in delivering treatment to children with ASD or a related condition. Hours worked as a mental health behavioral aide or Level III EIDBI provider may be included in the required hours of experience~~.~~; or

6. Be a graduate student in a behavioral science, child development science, or related field, who is receiving clinical supervision from a qualified supervising professional to meet the clinical training requirements~~.~~; or

7. Be at least 18 years of age, fluent in a language in addition to English or is an individual certified by a Tribal government, complete the Department's training requirements for a Level III provider, and receive observation and direction from a qualified supervising professional or qualified Level I provider at least once a week until reaching 1,000 hours of supervised experience.

c. Level III EIDBI provider:

All Level III providers must ~~have the following experience and or training~~ be employed by an EIDBI agency and meet the following standards:

~~a.~~ 1. Be at least 18 years old;

~~b.~~ 2. Meet the Department's specific training requirements for a Level III provider; and one of the following:

~~i.~~ a. Have a high school diploma or general equivalency diploma (GED)or~~;~~;

~~ii.~~ b. Be fluent in a language in addition to English or receive certification from a Tribal government; or

~~iii.~~ c. Have one year of experience as a primary personal care assistant, community health worker, waiver service provider, or special education assistant to a child with autism spectrum disorder or a related condition within the previous five years~~;~~.

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

Components of EIDBI services:

1. ~~**Applied Behavior Analysis (ABA)**~~**EIDBI Interventions.** Interventions are individualized treatments based in behavioral and developmental sciences that address the child's medically necessary treatment goals. Interventions must be targeted to develop, enhance, or maintain the individual developmental skills of a child with ASD or a related condition to improve self-regulation, self-care, behavioral challenges, expressive communication, receptive communication, cognitive functioning, and safety ~~functional communication, social or interpersonal interaction, behavioral challenges and self-regulation, cognition, learning and play, self-care and safety~~.

   Qualified ~~ABA~~ providers: Qualified Supervising Professional ~~who is certified as a BCBA or BCBA-D~~, ~~ABA Developmental/Behavioral Professional (~~Level I Provider~~)~~, ~~ABA Developmental/Behavioral Practitioner (~~Level II Provider~~)~~, and ~~ABA Developmental/Behavioral Support Specialist (~~Level III Provider~~)~~.

2. ~~**Developmental and Behavioral Interventions (DBI)** are a range of individualized treatments based in developmental theory as well as behavioral sciences which are socially directed, highly engaging, and capitalize on natural motivators to strengthen primary relationships and support child development. DBI interventions focus on joint attention, social engagement and reciprocity, social and non-verbal communication, behavioral and self-regulation, cognition and play to promote development and address core functional deficits. DBI are provided as part of Department recognized single or multi-modality treatment programs.~~

   ~~Qualified providers: Qualified Supervising Professional, ABA or DBI Developmental/Behavioral Professional (Level I Provider), ABA or DBI Developmental/Behavioral Practitioner (Level II Provider), and ABA or DBI Developmental/Behavioral Support Specialist (Level III Provider).~~

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

2. **Observation and Direction** is the clinical direction and oversight by a qualified EIDBI provider to a same or lower level provider based on the required provider standards and qualifications regarding provision of EIDBI services to a child. The qualified provider delivers face-to-face observation and direction to a same or lower level provider regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for each child. This service is for the direct benefit of the child and provides a real time response to the EIDBI intervention to maximize the benefit for the child. It also informs any modifications needed to the methods to be implemented to support the accomplishment of outcomes in the Individual Treatment Plan.

   Qualified providers: Qualified Supervising Professional, Level I Provider, and Level II Provider.

3. **Family/Caregiver Training and Counseling** is specialized training and education provided, for the benefit of the child, to a family/caregiver to assist with the child's needs and development. The provider will observe, instruct and train the family/caregivers on the child's development status, and techniques and strategies to promote the child's development.

   Qualified providers: Qualified Supervising Professional, Level I Provider, and Level II Provider.

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

2. **Coordinated Care Conference** brings together the team of professionals that work with the child and family to develop and coordinate the implementation of the individual treatment plan (ITP)to assure that services are coordinated and integrated across providers and service delivery systems. Participants in the conference will perform some, or all, of the following:
   a. Coordinate and integrate information from the CMDE process
   b. Describe intensive treatment options and expectations across service settings;
   c. Document intensive treatment scope, modality, intensity, frequency and duration based on the CMDE recommendations and family choice;
   d. Review the child's progress toward goals with the child's family;
   e. Coordinate services provided to the child and family;
   f. Identify the level and type of parent involvement in the child's intensive treatment;
   g. Coordinate program transition; and
   h. Integrate care and services across service providers to ensure access to appropriate and necessary care including medically necessary speech therapy, occupational therapy, mental health, human services or special education;

   Qualified providers: May include any of the qualified providers including ~~Must be completed by~~ the Qualified Supervising Professional (QSP), ~~and may include~~ the CMDE Provider, Level I Provider, and Level II Provider.

3. **Individual Treatment Plan (ITP)** is a person-centered, written plan of care for a child receiving EIDBI services. This includes development, ongoing monitoring, and updating of the ITP. The ITP must be based on the CMDE, be culturally and linguistically appropriate, and include input from the child's family and legal representative, who must sign in addition to the QSP. The ITP specifies the:
   - child's functional goals, including baseline measures and projected dates of accomplishment, which are developmentally appropriate, and work toward generalization across people and environments;
   - treatment modality or modalities;
   - treatment intensity, frequency and duration;
   - setting
   - discharge criteria;

4.b. Early and periodic screening, diagnosis, and Treatmentservices.(continued)

- Reflect the values, goals, preferences, culture and language of the child's family.

Qualified providers: ~~Must be completed by the Qualified Supervising Professional~~ Qualified Supervising Professional, Level I Provider, and Level II Provider.

~~The child and family's primary spoken language, culture and valuesmust be considered throughout EIDBI services, including the diagnosis,CMDE, individual treatment plan development, progress monitoring, parent education and support services and coordinationof care. A language interpreter must be provided when needed.~~

EIDBI is not intended to replace services provided in school or other settings. Each child's individualized treatment plan must document that EIDBI services coordinate with, but do not include or replace special education and related services defined in the child's individualized educational plan (IEP), or individualized family service plan (IFSP), when the service is available under theIndividuals with Disabilities Education Improvement Act of 2004 (IDEA) through a local education agency. This provision does not preclude EIDBI treatment during school hours.

~~EIDBI is provided in the most integrated and inclusivesetting possible that supports, promotes, and allows:~~

- ~~inclusion and participation in the child's home and community life to the fullest extent possible as desired by and determined medically appropriate to the age, condition, and needs of the child by their legal representative in collaboration with a QSP qualified supervising professional andthrough the CMDE process;~~
- ~~opportunities for self sufficiency, developing and maintainingsocial relationships and natural supports, and generalization of targeted skills across people and environments; and~~
- ~~a balance between risk and opportunity, meaning the least restrictive supports or interventions necessary are providedin the most integrated settings in the most inclusive manner possible.~~

EIDBI does not include services provided by a parent, legal guardian or legally responsible person.

4.c. Family planning services and supplies.

- Family planning services and supplies are health services or family planning supplies concerned with the voluntary planning of the conception and bearing of children and related to a recipient's condition of fertility.

- HIV blood screening testing performed as part of a package of sexually transmitted disease (STD) tests provided in conjunction with a family planning encounter is a family planning service. Counseling performed before and after the HIV blood screening test is also a covered family planning service.

- Family planning services and supplies are covered services if the recipient requested the service, and the service is provided with the recipient's full knowledge and consent, and the provider complies with 42 CFR §441.250 to 441.259 concerning informed consent for voluntary sterilizations.

- The following services are not covered:

  a. Reversal of voluntary sterilization;
  b. Hysterectomies for the purpose of sterilization;
  c. Artificial insemination; ~~and~~
  d. Fertility drugs when specifically used to enhance fertility; and
  e. In vitro fertilization.

5.a. Physicians' services:

- **Psychiatric services** may require prior authorization as specified in the Minnesota Health Care Program Provider Manual and on the agency's website. Coverage includes: diagnostic assessment, psychological testing, neuropsychological services, individual psychotherapy, family psychotherapy, multiple family group psychotherapy, group psychotherapy, medication management, electroconvulsive therapy single seizure, explanation of findings, unlisted psychiatric service or procedure, and biofeedback training.

- **Sterilization procedures:** Physicians must comply with all requirements of 42 CFR Part 441, Subpart F concerning informed consent for voluntary sterilization procedures.

- **Abortion services**: These services are covered: ~~when due to a physical condition, the abortion is medically necessary to prevent death of a pregnant woman, and in cases where the pregnancy is the result of rape or incest. Cases of rape and incest must be reported to legal authorities unless the treating physician documents that the woman was physically or psychologically unable to report.~~

  (1) if the pregnancy is the result of an act of rape or incest; or
  (2) in the case where a person suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the person in danger of death unless an abortion is performed.

- **Psychiatric consultations:** Consultations with psychiatrists, psychologists, licensed independent clinical social workers, licensed marriage and family therapists, and advanced practice registered nurses certified in psychiatric mental health by primary care physicians and other providers authorized to bill for physician services are covered services. If the recipient consents, consultation may occur without the recipient present. Payment for the consultation is made pursuant to Attachment 4.19-B, item 5.a.

- **Optometry services:** Physician services include services of the type which an optometrist is also legally authorized to perform and such services re reimbursed whether furnished by a physician or an optometrist.

- **Early Intensive Developmental and Behavioral Intervention (EIDBI) services:** A physician with a specialty in developmental or behavioral pediatrics and with at least 2,000 hours of experience and/or training in the examination and/or treatment of children with autism spectrum disorder (ASD) or a related condition, or equivalent documented coursework at the graduate level by an accredited university in the areas of ASD diagnostics, ASD developmental and behavioral treatment strategies and typical child development may act as the qualified supervising professional and provide EIDBI services as described in item 4.b.

5.a. Physicians' services (continued):

- **Prior Certification:** Physicians must request and obtain certification prior to admitting medical assistance recipients for inpatient hospital services, except for emergencies, delivery of a newborn, inpatient dental procedures, or inpatient hospital services for which a recipient has been approved under Medicare.

- **Delivery of services:** Physician services must be provided by or under the supervision of a medical doctor or doctor of osteopathy licensed under Minnesota Statutes, §147 and within the scope of practice defined by law. Supervised physician services are provided by enrolled physician assistants, physician extenders and community health workers providing patient education for health promotion and disease management.

- **Organ transplants:** These services are covered in accordance with the standards and statutory authority provided in Attachment 3.1-E.

- **Physical therapy, occupational therapy, and speech, language, and hearing therapy services:** Coverage of these services is limited to services within the limitations provided under items 11.a. to 11.c., Physical therapy and related services.

- **Anesthesia services:** Anesthesia services must be provided under supervision. At a minimum, physicians provide supervision. Anesthesiologists may personally perform or may medically direct (supervise) the services.

- **Physician services to pregnant women:** Physicians providing these services must be certified by the Department, through a provider agreement, as qualified to provide services to pregnant women.

- **Physician services to children under 21 years of age:** Physicians providing these services must be certified by the Department, through a provider agreement, as qualified to provide services to children under 21 years of age.

- **Pediatric vaccines:** Physicians who administer certain pediatric vaccines (i.e., vaccines that are part of the Minnesota Vaccines for Children Program) within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program. The Minnesota Vaccines for Children Program is established pursuant to §1928 of the Act.

5.a. Physicians' services (continued):

- ~~**Provider-directed care coordination**~~ **Health care home** services: Health care home ~~**provider-directed** care coordination~~ services are physicians' services provided in a clinical setting to recipients with complex and chronic medical conditions. All aspects of care are coordinated by the clinical staff team, which must be managed by a physician, nurse practitioner, or a physician assistant under the supervision of a physician. The team must include a dedicated care coordinator. Payment for this service ~~must be in conjunction with payment for an evaluation and management visit and is made no more frequently than once every six months~~ cannot be made more than once per patient per month.

  The service is comprised of the following components:

  A. Identifying recipients appropriate for health care home services ~~provider-directed care coordination~~ and matching intervention with need.
     1. This service is medically necessary for people with ~~five~~ one or more major chronic ~~diagnoses~~ conditions that are recurrent or persist for at least ~~one year~~ six months. Based on established methodologies, recipients with ~~chronic diagnoses~~ major chronic conditions are grouped as follows:
        - Group 1: those with ~~5-6 chronic diagnoses~~ 1-3 major chronic conditions;
        - Group 2: those with ~~7-9 chronic diagnoses~~ 4-6 major chronic conditions;
        - Group 3: those with 7-9 ~~chronic diagnoses~~ major chronic conditions:
        - Group 4: those with 10 or more ~~chronic diagnoses~~ major chronic conditions.

  B. Assessing an identified recipient's health status, risk factors, self-management skills, adherence to a treatment plan, and knowledge of and adherence to a prescribed medication regimen;

  C. Partnering with the recipient and/or family in decision-making through care team meetings with the recipient and/or family;

  D. Developing a comprehensive, individualized care plan where warranted due to patient complexity, detailing the recipient's specific medical needs and specific plans for all aspects of medical care, including preventive care, chronic care, acute care, and when appropriate, end-of-life-care and advanced

5.a. Physicians' services (continued):

directives, while incorporating social service needs and cultural preferences;

E. Documenting all levels of care provided;

F. Coordinating care with other medical providers who are responsible for pertinent aspects of care as defined in the individual care plan;

G. Conducting periodic monitoring and evaluating a recipient's response to care provided including face-to-face contact with the primary care provider occurring at least once every six months;

H. Providing an annual comprehensive review to identify, resolve and prevent problems in utilization of care;

I. Providing available access to medical professionals with knowledge of the recipient's medical history 24 hours per day and seven days per week;

J. Assisting recipients in improving health outcomes using evidence-based guidelines and protocols;

K. Promoting behavior modification aimed at encouraging lifestyle changes to support health self-management;

Providers of health care home services ~~provider-directed care coordination~~ must be certified by the Department as having the capacity to provide the components described in items A through K, above and as qualified to engage in the following:

1. Quality improvement activities, including:

a. Participating in a quality improvement training program including ongoing training on care coordination, evidence based medicine and best practices;

b. Creating and following clinic-level, team-based internal quality improvement processes;

c. Analyzing clinic processes and patient outcome measures.

5.a. Physicians' services (continued):

d. Participating in quality improvement processes with other providers in order to develop and share best practices.

2. Create and maintain patient information in a searchable, internal clinical registry for the following purposes:
   a. Provide reminders and follow-up for comprehensive preventive care according to nationally accepted guidelines;
   b. Manage chronic illness, organize patient care and track interventions;
   c. Track patient information including diagnoses, primary language and cultural preferences and needs.
3. Designate a dedicated care coordinator to:
   a. Provide information, support and resources to ensure ~~kjm,~~ that the recipient adheres to therapeutic regimens;
   b. Provide information about available community and social service providers necessary for improvement and maintenance of optimal health outcomes;
   c. Provide education and training to enhance recipient understanding of and appropriate management of the recipient's condition(s). This includes education about self-management, appropriate use of resources, how to navigate the health care system, and how the primary care provider will work with the recipient to develop a plan of care where warranted due to patient complexity, in coordination with the recipient and the recipient's family and caregivers.

In-reach care coordination services:

Services by physicians include supervision of an in-reach care coordinator who documents and assesses a recipient's emergency room use, develops and implements short-term plans to reduce the recipient's too-frequent (three or more times in the previous four consecutive months) or non-urgent emergency room use, and when appropriate, develops and implements a plan to transition the recipient to a more permanent care coordination or case management relationship so that the recipient's continuum of care needs can continue to be met outside of the emergency room. Recipients may receive up to 80 hours of in-reach care coordination in a sixty day period twice per calendar year.

5.a. Physicians' services (continued):

Community Paramedic Services:
Services provided by medical directors of ambulance services include supervision of a community paramedic who provides services to recipients who have received hospital emergency department services three or more times in a period of four consecutive months in the past 12 months, or an individual who has been identified by the individual's primary health care provider for whom community paramedic services would likely prevent admission to or would allow discharge from a nursing facility or would likely prevent readmission to a hospital or nursing facility. Services provided by a community paramedic are based on a care plan created by the primary care provider (a physician, physician's assistant, or a nurse practitioner) in consultation with the medical director of the ambulance service and may include health assessments, chronic disease monitoring and education, medication compliance, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow-up care, and minor medical procedures. Services provided by the community paramedic under the care plan must be coordinated with care received by the recipient from other community providers in order to prevent duplication of services.

A community paramedic must be certified in accordance with Minnesota Statutes, section 144E.28.

Community Emergency Medical Technician Services:
Services provided by medical directors of ambulance services include supervision of a community emergency medical technician (CEMT). A CEMT may provide:

- A ~~post-hospital~~ post-discharge visit when ordered by a treating physician after discharge from a hospital or nursing facility. The ~~post-hospital~~ post-discharge visit includes:
  1) verbal or visual reminders of discharge orders;
  2) recording and reporting of vital signs to the patient's primary care provider;
  3) confirmation of access to medications;
  4) confirmation of access to food; and
  5) identification of hazards in the home.

- A safety evaluation to a recipient who has repeat ambulance calls due to falls, ~~has been discharged from a nursing home,~~ or has been identified by the recipient's primary care provider as at risk for nursing home placement. The safety evaluation includes:
  1) confirmation of access to medications;
  2) confirmation of access to food; and
  3) identification of hazards in the home.

A CEMT must be certified in accordance with Minnesota Statutes, section 144E.275, subd. 7.

5.a. Physicians' services (continued):

The services specified below are **not** covered services for purposes of medical assistance payment:

1. Surgery performed on the wrong patient;
2. Surgery performed on the wrong body part that is not consistent with the documented informed consent for that patient;
3. Performing the wrong surgical procedure on a patient that is not consistent with the documented informed consent for that patient; or
4. Physicians' services related to hospital-acquired conditions or treatment as defined in Attachment 4.19-A, Sections 2.0 and 12.3, for which hospital reimbursement is prohibited, if the physicians' services were provided by a physician who delivered care that contributed to or caused the adverse health care event or hospital-acquired condition.

5.b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act

~~Limitations to coverage are the same as those identified in item 10, Dental services.~~

6. Medical care and any other type of remedial care:

- See Items 6.a. through 6.d.

6.a. Podiatrists' services:

- Podiatry services as provided by a podiatrist within the scope of practice defined in Minnesota Statutes, chapter 153 are covered services with the following limitations:

    1) Payment for the debridement or reduction of pathological toenails and of infected or eczematized corns or calluses is limited to once every 60 days.

    2) Payment for the debridement or reduction of nonpathological toenails and of noneczematized corns or calluses is limited to the following conditions:

        A) The recipient has a diagnosis of diabetes mellitus, arteriosclerosis obliterans, Buerger's disease, chronic thrombophlebitis, or peripheral neuropathies involving the feet. The service is eligible for payment only once every 60 days unless the service is required more often to treat ulcerations or abscesses complicated by diabetes or vascular insufficiency and is medically necessary.

        B) The recipient who is not a resident of a long-term care facility has a medical condition that physically prevents him or her from reducing the nail, corn, or callus.

    3) A podiatry service provided to a recipient of a long-term care facility must result from a self referral or a referral by a registered nurse or a licensed practical nurse who is employed by the facility or the recipient's family, guardian, or attending physician.

- The following services are not eligible for payment:

    1) stock orthopedic shoes;
    2) surgical assistants;
    3) local anesthetics that are billed as a separate procedure;
    4) operating room facility charges;
    5) foot hygiene;
    6) use of skin creams to maintain skin tone;
    7) service not covered under Medicare, or service denied by Medicare as not medically necessary;
    8) debridement or reduction of the nails, corns, or calluses except as allowed above; and,
    9) general foot care that can be reasonably performed by nursing staff of long-term care facilities for recipients who reside in long-term care facilities.

6.b. Optometry~~ists'~~ services.

Vision care is described in section 5.a. of this attachment.

~~• Optometry services are covered if they are within the scope of practice for optometrists under State law or rule.~~

~~• Item 12.d. contains the list of eyeglass services that are not eligible for payment.~~

6.b. Optometrists' services. (continued.)

~~(14) Purchase of eyeglasses or lenses not covered by a contract obtained through the competitive bidding process.~~

~~(15) Backup eyeglasses.~~

~~(16) Photochromatic lenses, except for a recipient who has a diagnosis of albinism, achromatopsia, aniridia, blue cone monochromatism, cystinosis, or retinitis pigmentosa, or any other condition for which such lenses are medically necessary.~~

~~(17) Transition lenses.~~

~~(18) High index plastic lenses.~~

~~(19) Eyeglasses or lenses for occupational or educational needs, unless they is the recipient's only pair and are necessary for vision correction.~~

6.c. Chiropractors' services.

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- ~~Coverage is limited to medically necessary evaluation and manual manipulation of the spine for treatment of incomplete or partial dislocations, and the x-rays that are needed to support a diagnosis of subluxation.~~

- ~~Payment for manual manipulation of the spine of a recipient is limited to six manipulations per month and, effective January 1, 2011, twelve manipulations per year unless prior authorization for a greater number of manipulations is obtained.~~

- ~~Payment is limited to one annual evaluation unless prior authorization for additional evaluations is obtained.~~

6.d. Other practitioners' services.

A. **Mental health** services are limited to those provided by the following mental health professionals within the applicable scope of licensure:

1. licensed psychologist;
2. licensed independent clinical social worker;
3. an advanced practice registered nurse who is licensed and is certified as a clinical nurse specialist in mental health, or is certified as a nurse practitioner in pediatric or family or adult mental health nursing by a national nurse certification organization;
4. licensed marriage and family therapists. Covered Medicaid mental health services do not include marriage counseling; and
5. licensed professional clinical counselor.
6. ~~a licensed physician if the physician is: certified by the American Board of Psychiatry and Neurology, certified by the American Osteopathic Board of Neurology and Psychiatry, eligible for board certification in psychiatry.~~

Mental health services are subject to the same limitations as psychiatric services described under Item 5.a., Physicians' services.

Under the supervision of a~~n enrolled psychiatrist or other~~ mental health professional listed in this item, a clinical trainee may provide diagnostic assessment, clinical care consultation, and explanation of findings or psychotherapy. A clinical trainee may also provide psychological testing under the supervision of a licensed psychologist. A clinical trainee must:

1. have completed an accredited graduate program of study to prepare the staff person for independent licensure as a mental health professional and in compliance with the requirements of the applicable health-related licensing board, including requirements for supervised practice; or
2. be enrolled in an accredited graduate program of study to prepare the staff person for independent licensure as a mental health professional and participating in a practicum or internship through the individual's graduate program~~.~~; or
3. have completed a practicum or internship and has not yet taken or received results from required test or is waiting for the final licensure decision.

~~A clinical trainee may provide psychological testing under the supervision of a licensed psychologist.~~

~~A licensed physician assistant working in an inpatient hospital under the supervision of a psychiatrist, or physician eligible to be licensed as a psychiatrist, may provide medication management and training in medication self-administration. A licensed physician assistant with 2,000 hours of clinical experience in the treatment of mental illness, and meeting the supervision requirements above, may also provide the service in an outpatient setting.~~

Services by mental health professionals include developing individual treatment plans to promote good mental health and self-management of mental health conditions, and directing and

6.d.a. Other practitioners' services, (continued)

overseeing the implementation of the individual treatment plans by community health workers.

In-reach care coordination services:
Services by mental health professionals include supervision of an in-reach care coordinator who documents and assesses a recipient's emergency room use, develops and implements short-term plans to reduce the recipient's too-frequent (three or more times in the previous four consecutive months) or non-urgent emergency room use, and when appropriate, develops and implements a plan to transition the recipient to a more permanent care coordination or case management relationship so that the recipient's continuum of care needs can continue to be met outside of the emergency room. Recipients may receive up to 80 hours of in-reach care coordination in a sixty-day period twice per calendar year.

Officer-involved, community-based care coordination:
Officer-involved, community-based care coordination diverts recipients from the criminal justice system by addressing the recipient's mental health, chemical health, social, economic, and housing needs, by connecting recipients with available covered services. The service is provided to individuals who have been involved with law enforcement, but not incarcerated, and who have screened positive for benefitting from treatment for a mental illness or substance use disorder. Recipients may receive services for up to 60 days following initiation of services. Services are provided by the following individuals who are either employed by a county or contract with a county or are an employee of or under contract with 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 to provide post-arrest officer-involved community-based care coordination and is qualified under one of the following criteria:

- A licensed mental health professional, as defined above;
- A mental health practitioner, as defined in item 13.d., working under the clinical supervision of a mental health professional; or
- A certified peer specialist, as defined in item 13.d, working under the clinical supervision of a mental health professional.

6.d.a. Other practitioners' services, (continued)

- an individual qualified as a licensed alcohol and drug counselor as defined in item 13d.; or
- A recovery peer as defined in item 13d. working under the supervision of an individual qualified as a licensed alcohol and drug counselor.

6.d. Other practitioners' services. (continued)

B. **Public health nursing services**

Medical Assistance covers public health nursing services that are medically necessary and within the public health nurse's scope of practice. ~~are limited to~~:

Medical Assistance Covers prenatal and postnatal home visits provided in accordance with Department-approved, evidence-based treatment models. Postpartum visits can be provided up to three years after the birth of the child. The Department has approved the following models: Nurse Family Partnership, Healthy Families America, Family Spirit, and Family Connects.

~~1) Nursing assessment and diagnostic testing;~~
~~2) Health promotion and counseling;~~
~~3) Developing a care plan to promote good health and self-management of health conditions, and directing and overseeing the implementation of the care plan by a community health worker when a certified public health nurse operates under the direct authority of a city, county, tribe or school district.~~
~~4) Nursing treatment;~~
~~5) Immunization;~~
~~6) Administration of injectable medications;~~
~~7) Medication management and the direct observation of the intake of drugs prescribed to treat tuberculosis;~~
~~8) Tuberculosis case management, which means:~~
~~a) assessing an individual's need for medical services to treat tuberculosis;~~
~~b) developing a care plan that addresses the needs identified in subitem a);~~
~~c) assisting the individual in accessing medical services identified in the care plan; and~~
~~d) monitoring the individual's compliance with the care plan to ensure completion of tuberculosis therapy; and~~

Public health nurses perform ~~A~~assessments, reassessments, and service updates ~~to determine medical necessity~~ for personal care services. ~~Assessments, reassessments, and service updates~~ An initial assessment for personal care services must be conducted face-to-face~~ are conducted by county public health nurses or certified public health nurses under contract with the county~~. A face-to-face assessment is also required when there is a significant change in health status, when the recipient uses PCA Choice, and after two ~~phone~~ service update~~s~~ ~~assessments~~ have been completed by phone.

~~Assessments for personal care services must be conducted initially, in person, for people who have never had a public health nurse assessment. The initial assessment must include:~~

6.d. Other practitioners' services. (continued)

B. **Public health nursing services**, continued.

~~a) documentation of:~~
~~a. dependencies in activities of daily living;~~
~~b. presence of complex health-related needs; and~~
~~c. presence of specific behaviors including physical aggression towards self or others, or destruction of property;~~
~~b) determination of need, including meeting access criteria as described on page 78z;~~
~~c) identification of appropriate services;~~
~~d) service plan development;~~
~~e) coordination of services;~~
~~f) referrals and follow-up to appropriate payers and community resources;~~
~~g) completion of required reports;~~
~~h) if a need is determined, recommendation and receipt of service authorization; and~~
~~i) recipient education.~~

Reassessments for personal care services are conducted face-to-face, and at least annually or when there is a significant change in the recipient's condition and need for services. A service update may substitute for a reassessment as described below. ~~The reassessment includes:~~

~~a) a review of initial baseline data;~~
~~b) an evaluation of service effectiveness;~~
~~c) a redetermination of need for service;~~
~~d) a modification of the service plan, if necessary, and appropriate referrals;~~
~~e) an update of the initial forms;~~
~~f) if a need is redetermined, recommendation and receipt of service authorization; and~~
g) ~~ongoing recipient education.~~

Service updates for personal care services are conducted in lieu of an annual face-to-face ~~reassessment~~ when a recipient's condition or need for personal care assistant services has not changed substantially, or between required assessments when the recipient or provider requests a temporary increase in services until ~~a~~n face-to-face ~~in-person~~ review is conducted. The service update ~~includes all the elements listed in items a) through g), above, but~~ does not require ~~a~~n face-to-face ~~in-person~~ visit.

6.d. Other practitioners' services. (continued)

B. **Public health nursing services**, continued.

Public health nurses who administer pediatric vaccines, as noted in item 5.a., Physicians' services, within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

6.d.Other practitioners' services. (continued)

C. Acupuncture Services

Effective for services delivered on or after ~~January~~ February 1, 201~~2~~6, Medical Assistance covers medically necessary acupuncture services when provided within the qualified provider's scope of practice~~coverage is limited to the treatment of chronic pain, which is pain with a documented duration of a least six consecutive months that has been unresponsive to other forms of therapy~~.

Qualified providers include licensed acupuncturists or other licensed practitioner for whom acupuncture is within the practitioner's scope of practice and who have specific acupuncture training or credentialing, including chiropractors, osteopaths and physicians.

6.d. Other practitioners' services. (continued)

D. **Certified registered nurse anesthetist (CRNA) services** may be provided by a registered nurse who is certified by the Council on Certification of the American Association of Nurse Anesthetists, or certified by the Council on the Recertification of Nurse Anesthetists of the American Association of Nurse Anesthetists, or who has graduated within the past 18 months from a nurse anesthesia program that meeting the standards of the Council on Accreditation of Nurse Anesthesia Educational Programs and is awaiting initial certification.

Coverage is limited to the following:

(1) services provided by a CRNA who is:

(a) practicing independently; ~~or~~

(b) if not practicing independently, services that are not ~~reimbursed~~ paid as part of the inpatient hospital's base rate under Attachment 4.19-A and for which the hospital has notified the Department by July 1, 1991, of ~~their~~ its intent to exclude CRNA services from ~~their~~ its charges; or

(c) practicing under the medical direction of an anesthesiologist or physician.

(2) time elapsed from the preparation of the patient for induction to the time when the CRNA is no longer in attendance.

6.d. Other practitioners' services. (continued.)

E. **Nurse practitioner services** are limited to:

(1) Services performed by ~~an adult~~ a nurse practitioner~~, obstetrical/gynecological nurse practitioner, neonatal nurse practitioner, or geriatric nurse practitioner~~ certified by the appropriate certification entity and provided within the scope of practice of the nurse practitioner's license as a registered nurse; and

(2) The types of services covered by Medical Assistance as physicians' services under item 5.a. ~~and which~~ that are within the scope of the nurse practitioner's license as a registered nurse.

Nurse practitioners who administer pediatric vaccines as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

6.d. Other practitioners' services. (continued)

F. ~~Phlebotomy and~~ **Case management services** provided as a component of ~~the~~ receiving ~~Clozaril patient monitoring system~~ clozapine is limited to:

~~(1) Venipuncture, which may be provided by any outpatient hospital, laboratory, or physician that meets the applicable provider requirements under Item 2.a., Outpatient hospital services, Item 3, Other laboratory and x-ray services, or Item 5.a., Physicians' services.~~

~~(2)~~ • Patient monitoring services~~, which may be~~ provided by ~~any~~ a physician, registered psychiatric nurse under the supervision of a physician, or pharmacist in an outpatient hospital, physician, clinic, or pharmacy that:

a. meets the applicable provider requirements under Item 2.a., Outpatient hospital services, Item 3, Other laboratory and x-ray services, Item 5.a., Physicians' services, or Item 12.a., Prescribed drugs; and

b. is registered with ~~Sandoz Pharmaceuticals Corporation~~ a manufacturer of clozapine as an entity eligible to participate in ~~the Clozaril Patient Monitoring System~~ a patient monitoring system.

6.d. Other practitioners' services. (continued)

G. Coverage of ~~**health maintenance**~~ **managed care organization services** provided consistent with 42 CFR Part ~~434~~ 438 and state law.

6.d. Other practitioners' services. (continued)

I. Medication therapy management services

Medication therapy management services are provided by qualified, licensed pharmacists to recipients to optimize the therapeutic outcomes of a recipient's medications. It is provided to recipients taking a prescription medication to treat or preventone or more chronic medical conditions.

Pharmacists must have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Minnesota Board of Pharmacy and the American Council of Pharmaceutical Education.

Medication therapy management services that are otherwise covered as direct face-to-face services may be provided via telehealth. ~~two-way, interactivevideo to:~~

- ~~an ambulatory care site if the recipient is more than twenty miles from any enrolled medication therapy management provider and the interactive video site is in a trade area that does notcontain an enrolled medication therapy management provider; or~~
- ~~a recipient's home, during a covered home health care visit.~~

The service is comprised of the following components:

A. assessing a recipient's health status;
B. developing a medication treatment plan;
C. monitoring and evaluating a recipient's response to the therapy
D. providing a comprehensive medication review to identify, resolve,and prevent medication-related problems;
E. documenting the care provided and communicating essential information to a recipient's primary care providers;
F. providing oral education and training to enhance recipient understanding and appropriate use of medications;
G. providing information, support services, and resources to enhance recipient adherence to therapeutic regimens;
H. coordinating and integrating medication therapy management services within the broader health care services provided to a recipient.

7.a Intermittent or part-time nursing services provided by a home health agency, or by a registered nurse when no home health agency exists in the area. (continued)

administer or prefill a medication;

c) a visit made by a nurse solely to train other home health agency workers;

d) nursing services that can reasonably be obtained as outpatient services;

e) Medicare evaluation or administrative nursing visits for dually eligible recipients that do not qualify for Medicare visit billing;

f) skilled nurse visits (beyond the first nine ~~five~~ during a calendar year) that are not ~~prior~~ authorized; and

g) nursing visits when not medically necessary~~.~~;

h) homemaker services, social services, educational services, and services not prescribed by a physician.

7.b. Home health aide services provided by a home health agency.

Covered home health aide services are those provided by a Medicare-certified home health agency that are:

a) medically necessary;
b) ordered by a physician pursuant to a face-to-face or telemedicine encounter occurring within 90 days prior or within 30 days after the start of services;
c) documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once every 60 days; and
d) provided to the recipient in any setting in which normal life activities take place, ~~at the recipient's own place of residence that is a place~~ other than a hospital, nursing facility, or intermediate care facility for the developmentally disabled ~~mentally retarded~~ (ICF/DD~~MR~~).

Home health aide services must be provided under the direction of a registered nurse.

Home health aide services must be employees of a home health agency and be approved by the registered nurse to perform medically oriented tasks written in the plan of care.

Homemaker services, social services, educational services, and services not prescribed by the physician are not paid by medical assistance.

7.c. Medical supplies, equipment and appliances suitable for use in any setting in which normal life activities take place, as defined at 42 CFR § 440.70(c)(1).

Covered medical supplies, equipment and appliances suitable for use in any setting in which normal life activities take place, as defined at 42 CFR § 440.70(c)(1) are those that are:

a) medically necessary;
b) ordered by a physician, or for asthma reduction devices, ordered by a physician or other licensed practitioner acting within the scope of their license, and if required under the Medicare program, ordered pursuant to a face-to-face or telemedicine encounter with a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant, occurring within six months prior or within 30 days after the start of services;
c) documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once a year; and
d) provided to the recipient in any setting in which normal life activities take place, other than a hospital, nursing facility, or intermediate care facility for the developmentally disabled (ICF/DD).

Medical supplies and equipment ordered in writing by a physician arepaid with the following limitations:

1) A purchase of nondurable medical supplies not requiring prior authorization must not exceed an amount necessary to provide a one-month supply.

2) Maintenance or service made at routine intervals based on hours ofuse or calendar days to ensure that equipment in proper working order is payable.

3) The cost of a repair to durable medical equipment that is rented or purchased by the Medical Assistance program under a warranty is not eligible for medical assistance payment if the repair is covered by the warranty.

4) In the case of rental equipment, the sum of rental payments during the projected period of the recipient’s use must not exceed the purchase price allowed by medical assistance unless the sum of the projected rental payments in excess of the purchase price receives prior authorization. All rental payments must apply to purchase of the equipment.

5) For individuals not receiving Medicare, the following diabetic testing supplies may only be dispensed by a pharmacy: blood glucose meters, testing strips, lancets, lancing devices, and control solutions.

Augmentative and alternative communication devices are defined as devices dedicated to transmitting or producing messages or symbols in a manner thatcompensates for the impairment and disability of a recipient with severe expressive communication disorders. Examples include communication picturebooks, communication charts and boards, and mechanical or electronic dedicated devices.

Asthma Reduction devices are devices proven to reduce common asthma triggers in the home of a child. Examples include HEPA filters, and mattress or pillow covers.

7.c. Medical supplies, equipment and appliances suitable for use in any setting in which normal life activities take place, as defined at 42 CFR § 440.70(c)(1). (continued)

Prior authorization must be obtained for all augmentative and alternative communication devices.

Coverage of augmentative and alternative communication devices is limited to:

1. Evaluation for use of augmentative and alternative communication devices to supplement oral speech.
2. Speech pathologists may only provide modification and programming of augmentative and alternative communication devices.
3. Construction, programming or adaptation of augmentative and alternative communication devices.

Augmentative and alternative communication devices are not covered if facilitated communication is required in addition to the devices.

The following medical supplies and equipment are not eligible for payment:

1. Medical supplies and equipment that are not covered under Medicare except for raised toilet seats; bathtub chairs and seats; bath lifts; prosthetic communication devices; and any item determined by prevailing community standards or customary practice ~~to be an appropriate and effective medical necessity that meets quality and timeliness standards as the most cost-effective medical supply or equipment available for the medical needs of the recipient and represents an effective and appropriate use of medical assistance funds, is within the specified service limits of the Medical Assistance program, and is personally furnished by a provider.~~

2. Routine, periodic maintenance on medical equipment owned by a long-term care facility or hospital when the cost of maintenance is billed to medical assistance on a separate claim for payment.

7.c. Medical supplies, equipment and appliances suitable for use in the home. (continued)

3) Durable medical equipment that will serve the same purpose as equipment already in use by the recipient.

4) Medical supplies or equipment requiring prior authorization when prior authorization is not obtained before billing.

5) Dental hygience supplies and equipment.

6) Stock orthopedic shoes.

- Medical suppliers who do not participate or accept Medicare assignment must refer and document the referral of dual eligibles to Medicare providers when Medicare is the appropriate payer.

7.d. Physical therapy, Occupational therapy or Speech pathology and Audiology services provided by a home health ~~or rehabilitation~~ agency.

Physical therapy, occupational therapy, and speech pathology and audiology services provided by a home health agency are:

a) medically necessary;
b) ordered by a physician pursuant to a face-to-face or telemedicine encounter occurring within 90 days prior or within 30 days after the start of services;
c) documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once every 60 days; and
d) provided to the recipient in any setting in which normal life activities take place, other than a hospital, nursing facility, or intermediate care facility for the developmentally disabled (ICF/DD) unless skilled nurse visits have been prior authorized for less than 90 days for a resident at an ICF/DD in order to prevent an admission to a hospital or nursing facility and is not required to be provided by the facility under 42 CFR Part 483, subpart I.

- **Covered physical therapy services** are ~~those prescribed by a physician or other licensed practitioner of the healing arts and~~ provided to a patient by a qualified physical therapist, pursuant to 42 CFR §440.110, or qualified physical therapist assistant under the direction of a qualified physical therapist.

- **Covered occupational therapy services** are ~~those prescribed by a physician or other licensed practitioner of the healing arts and~~ provided to a patient by a qualified occupational therapist, pursuant to 42 CFR §440.110, or qualified occupational therapy assistant under the direction of a qualified occupational therapist.

- **Covered speech, language, and hearing therapy services** are ~~those diagnostic, screening, preventive or corrective services prescribed referred by a physician or other licensed practitioner of the healing arts and~~ provided by a qualified speech pathologist~~, pursuant to 42 CFR §440.110, or a qualified~~ audiologist, pursuant to 42 CFR §440.110, in the practice of his or her profession.

- **Restorative therapy services**, as described in items 11a to 11c, are covered only when there is a medically appropriate expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time.

7.d. Physical therapy, Occupational therapy or Speech pathology and Audiology services provided by a home health ~~or rehabilitation~~ agency. (continued)

- **Specialized maintenance therapy**, as described in items 11a to 11c, is covered only when:

  - ordered by a physician~~'s or other licensed practitioner's of the healing arts~~;
  - the orders describe the ~~relate~~ necessity for specialized maintenance therapy in order to treat ~~to~~ the patient's particular medical condition(s); and

  - it is necessary for maintaining the patient's current level of functioning or for preventing deterioration of the patient's medical condition(s).

8. Private duty nursing services.

- Private duty nursing services are only covered when medically necessary, ordered in writing by the physician, and documented in a written plan of care that is reviewed and revised as medically necessary by the physician at least once every 62 days.
- Private duty nursing services are not reimbursable if a skilled nurse visit is appropriate, or if a personal care assistant can be utilized.
- Private duty nursing services may also be provided by a parent of a minor child, family foster parent, spouse or unpaid legal guardian, who must be a professional nurse and employed by a licensed private duty nursing agency ~~and must be included in the plan of care under direction by the physician~~.
- Private duty nursing services may be provided by a licensed registered nurse or licensed practical nurse who is the recipient's spouse, unpaid legal guardian, family foster parent or parent of a minor child, if:
  1) the nurse passes a criminal background check;
  2) the services are necessary to prevent hospitalization of the recipient; and
  3) one of the following are met:
     a. the nurse resigns from a part-time or full-time job to provide nursing care for the recipient;
     b. the nurse goes from a full-time job to a part-time job with less compensation for provide nursing care for the recipient;
     c. the nurse takes a leave of absence without pay to provide nursing care for the recipient; or
     d. because of labor conditions, special language needs, or intermittent hours of nursing care needed, the nurse is needed in order to provide adequate care to meet the medical needs of the recipient.
  4) Authorized private duty nursing services provided by a relative, family foster parent or unpaid legal guardian may not exceed 50 percent of the total approved nursing hours, or eight hours a day, whichever is less, up to a maximum of 40 hours per week regardless of the number of children or adults who receive services.

- Private duty nursing services include~~s~~ ongoing professional nursing services provided ~~by licensed registered nurses or licensed practical nurses employed by a Medicare-certified home health agency or self-employed~~ when the recipient requires more individualized and continuous care than can be provided during a skilled nurse visit, by licensed registered nurses or licensed practical nurses who are self-employed or employed by a class "A" licensed home care agency as required by state law.

- Department ~~prior~~ authorization is required for all private duty nursing services. ~~Prior a~~Authorization is based on medical necessity; physician's orders; the recipient's needs, diagnosis, and condition; an assessment of the recipient; the plan of care; and cost-effectiveness when compared to alternative care options. For recipients who meet hospital admission criteria, the Department shall not authorize more

8. Private duty nursing services. (continued)

than 16 hours per day of private duty nursing service with the following exceptions. ~~or~~ The Department may authorize up to 24 hours per day of private duty nursing service while a determination of eligibility is made for recipients who are applying for services under Minnesota's approved model home and community-based services waiver or during an appeal to the appropriate regulatory agency to determine if a health benefit plan is required to pay for medically necessary nursing services. For recipients who do not meet hospital admission criteria, the Department may authorize up to 9.75 hours per day of private duty nursing service. ~~Authorized private duty nursing services provided by a relative may not exceed 50 percent of the total approved nursing hours, or eight hours a day, whichever is less, up to a maximum of 40 hours per week.~~

Authorized units of private duty nursing service may be used in the recipient's home or outside of the recipient's home if normal life activities take the recipient outside of their home. To receive private duty nursing services at school, the recipient or his or her responsible party must provide written authorization in the recipient's care plan identifying the chosen provider and the daily amount of services to be used at school.

- Private duty nursing providers that are not Medicare certified must refer and document the referral of dual eligibles to Medicare providers when Medicare is the appropriate payer.

Recipients may receive shared private duty nursing services, defined as nursing services provided by a private duty nurse to two recipients at the same time and in the same setting at a reduced rate. Decisions on the selection of recipients to share private duty nursing services must be based on the ages of the recipients, compatibility, and coordination of their care needs.

8. Private duty nursing services. (continued)

~~that is licensed by the state, or outside the home or foster care home of one of the recipients when normal life activities, including attending school, take the recipients outside the home.~~ Shared private duty nursing services are allowed only for Medicaid recipients who would otherwise be eligible and qualified for private duty nursing services in their home or foster care home, pursuant to regulations at 42 CFR 440.80. When normal life activities, including attending school, take the Medicaid recipients sharing private duty nursing services outside the home or foster care home, they may utilize their approved hours in a child care program that is licensed by the State or operated by a local school district or private school, or an adult day care that is licensed by the State.

The provider must offer the recipient or responsible party the option of shared care. If accepted, the recipient or responsible party may withdraw participation at any time.

The private duty nursing agency must document the following in the health service record for each recipient sharing care:

a) authorization by the recipient or responsible party for the maximum number of shared care hours per week chosen by the recipient;
b) authorization by the recipient or responsible party for shared service provided outside the recipient's home;
c) authorization by the recipient or responsible party for others to receive shared care in the recipient's home;

8. Private duty nursing services. (continued)

d) revocation by the recipient or responsible party of the shared care authorization, or the shared care to be provided to others in the recipient's home, or the shared care to be provided outside the recipient's home; and

e) daily documentation of the shared care provided by each private duty nurse including:

1) the names of each recipient receiving shared care together;

2) the setting for the shared care, including the starting and ending times that the recipients received shared care; and

3) notes by the private duty nurse regarding changes in the recipient's condition, problems that may arise from the sharing of care, and scheduling and care issues.

In order to receive shared care:

a) the recipient or responsible party and the recipient's physician, in conjunction with the private duty nursing agency ~~home health care agency~~, must determine:

1) whether shared care is an appropriate option based on the individual needs and preferences of the recipient; and

2) the amount of shared care authorized as part of the overall authorization of private duty nursing services;

b) the recipient or responsible party, in conjunction with the private duty nursing agency, must approve the setting, grouping, and arrangement of shared care based on the individual needs and preferences of the recipients;

c) the recipient or responsible party, and the private duty nurse, must consider and document in the recipient's health service record:

1) the additional training needed by the private duty nurse to provide care to two recipients in the same setting and

8. Private duty nursing services. (continued)

to ensure that the needs of the recipients are appropriately and safely met;

2) the setting in which the shared private duty nursing care will be provided;

3) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting;

4) a contingency plan that accounts for absence of the recipient in a shared care setting due to illness or other circumstances. The private duty nurse will not be paid if the recipient is absent;

5) staffing backup contingencies in the event of employee illness or absence;

6) arrangements for additional assistance to respond to urgent or emergency care needs of recipients.

- The following services are not covered under medical assistance as private duty nursing services:

~~a) private duty nursing services provided by a licensed registered nurse or licensed practical nurse who is the recipient's spouse, legal guardian, or parent of a minor child, unless the following conditions are met:~~
~~1)the nurse passes a criminal background check;~~
~~2)the services are necessary to prevent hospitalization of the recipient; and~~
~~3)one of the following are met:~~
~~a.the nurse resigns from a part-time or full-time job to provide nursing care for the recipient;~~

~~b.the nurse goes from a full-time job to a part-time job with less compensation for provide nursing care for the recipient;~~

8. Private duty nursing services. (continued)

~~c. the nurse takes a leave of absence without pay to provide nursing care for the recipient; or~~

~~d. because of labor conditions, special language needs, or intermittent hours of nursing care needed, the nurse is needed in order to provide adequate to meets the medical needs of the recipient;~~

~~b)~~ a) private duty nursing services that are identified in the foster care placement agreement to be provided by the foster care provider who is a professional nurse as the responsibility of the foster care provider;

~~c)~~ b) private duty nursing services when other, more cost-effective, medically appropriate services are available;

~~d)~~ c) private duty nursing services provided to a resident of a hospital, nursing facility, intermediate care facility, or a licensed health care facility; and

~~e)~~ d) private duty nursing services provided by a licensed registered nurse or licensed practical nurse who is the foster care provider of a recipient who is under age 18.

State Plan under Title XIX of the Social Security Act

State/Territory: Minnesota

Section 1905(a)(9) Clinic Services

The state provides coverage for this benefit as defined at section §1905(a)(9) of the Social Security Act (the Act) and 42 C.F.R. 440.90 and as described as follows:

General Assurances

[Select all three checkboxes below.]

- ☑ The state assures services are furnished by a facility that is not part of a hospital in accordance with 42 C.F.R. 440.90.
- ☑ The state assures that services are furnished by facilities that are organized and operated to provide medical care to outpatients in accordance with 42 C.F.R. 440.90.
- ☑ The state assures that services are furnished under the direction of a physician or dentist in accordance with 42 C.F.R. 440.90(a).

Types of Clinic Services and Limitations in Amount, Duration, or Scope

[Select if applicable, describe below, and indicate if limits may be exceeded based upon state determined medical necessity criteria.]

- ☐ Limitations apply to all services within the benefit category.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(9) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #91). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act

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Section 1905(a)(9) Clinic Services

Types of Clinics and Services:

[**Select all that apply and describe below as applicable**]

☐ Behavioral Health Clinics **[Describe the types of behavioral health clinics below and select below if applicable.]:**

☐ Limitations apply only to this clinic type within the benefit category. **[Describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria.]**

☑ IHS and Tribal Clinics **[Select below if applicable.]:**

☐ Limitations apply only to this clinic type within the benefit category. **[describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria].**

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☑ Renal Dialysis Clinics **[Select below if applicable.]:**

☐ Limitations apply only to this clinic type within the benefit category. **[Describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria.]**

☑ Other Clinics **[Describe the types of clinics, if any limitations apply, and select below if applicable.]:**

Ambulatory surgical center services covered under this item are facility servicesfurnished in connection with a covered surgical procedure.

☑ Limitations apply only to this clinic type within the benefit category. **[Describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria.]**

The following ambulatory surgical center services are covered:
1.Nursing services and other related services of practitioners who are involved in the recipient's health care.
2.Drugs, medical supplies, and equipment commonly furnished by the ambulatory surgical· center in connection with surgical

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Section 1905(a)(9) Clinic Services

procedures. Drugs are limited to those which cannot be self-administered.

3.Diagnostic or therapeutic services that are directly related to the provision of a surgical procedure.
4.Blood, blood plasma, and platelets.
5.Anesthetics and any medical supplies, whether disposable or reusable, necessary for the administration of the anesthetics.

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Section 1905(a)(9) Clinic Services

Four Walls Exceptions

The state assures that the following services may be furnished outside of the clinic. **[Select the first and second checkbox; Do not select the second checkbox if the state does not enroll IHS or Tribal facilities as providers of clinic services.]:**

☑ Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address in accordance with 42 C.F.R. 440.90(b).

☑ Services furnished outside a clinic that is a facility of the Indian Health Service, whether operated by the Indian Health Service (IHS) or by a Tribe or Tribal organization (as authorized by the Indian Self-Determination and Education Assistance Act (ISDEAA), Pub. L. 93-638), by clinic personnel under the direction of a physician in accordance with 42 C.F.R. 440.90(c).

The state elects to cover the following services outside of the clinic **[Select all that apply.]:**

☐ Services furnished outside of a clinic that is primarily organized for the care and treatment of outpatients with behavioral health disorders, including mental health and substance use disorders, by clinic personnel under the direction of a physician in accordance with 42 C.F.R. 440.90(d) **[Describe the types of behavioral health clinics such exception applies to below.]:**

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☐ Services furnished outside of a clinic that is located in a rural area and is not a rural health clinic (as referenced in section §1905(a)(2)(B) of the Act and 42 C.F.R. 440.20(b) of this subpart) by clinic personnel under the direction of a physician in accordance with 42 C.F.R. 440.90(e) **[Select one of the checkboxes below and describe the definition of a rural area that applies to this exception.]:**

☐ A definition adopted and used by a federal governmental agency for programmatic purposes **[Describe below.]:**

☐ A definition adopted by a state governmental agency with a role in setting state rural health policy **[Describe below.]:**

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The state attests that **[Select the checkbox if the state elects to cover services outside of a clinic that is located in a rural area.]:**

☐ The selected definition of a rural area best captures the population of rural individuals that meets more of the four criteria that mirror the needs and barriers to access experienced by individuals who are unhoused:

- The population experiences high rates of behavioral health diagnoses or difficulty accessing behavioral health services;
- The population experiences issues accessing services due to lack of transportation;
- The population experiences a historical mistrust of the health care system; and
- The population experiences high rates of poor health outcomes and mortality.

Additional Benefit Description (Optional)

At its option the state may provide additional descriptive information about the benefit, beyond what is included in the federal statutory and regulatory definitions and descriptions. **[Describe below.]:**

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10. Dental services.

A. Medically necessary dental services for children under 21 years of age are covered in accordance with EPSDT requirements as described in section 1905(r) of the Social Security Act.

B. Coverage of dental services for pregnant women is limited to medically necessary dental services as defined in 42 CFR §440.100.

C. Coverage of dental services for adults other than pregnant women is limited to the following medically necessary services:
1. Periodic oral evaluation once per calendar year
2. Limited oral evaluation
3. Comprehensive oral evaluation once every five years
4. Bite wing x-rays, one series per calendar year
5. Periapical x-rays
6. Panoramic x-rays, no more than once every five years. Panoramic x-rays may be provided more frequently when medically necessary for diagnosis and follow-up of pathology and trauma. For recipients who cannot cooperate for intraoral film due to a disability or medical condition that does not allow for intraoral film placement, panoramic x-rays are covered no more frequently than once every two years.
7. Prophylaxis, ~~once~~four per calendar year
8. Fluoride varnish, once per calendar year
9. Fillings
10. Root canals for anterior and premolar teeth
11. Full mouth debridement no more than once every five years
12. Removable partial and full dentures, one appliance per dental arch every 6 years
13. Palliative treatment and sedative fillings for relief of pain
14. Surgical services limited to:
   ~~a.~~ extractions
   ~~b.~~ biopsies
   ~~c.~~ incise and drain
15. Treatment for periodontal disease

~~15~~16. The following services only when provided in conjunction with dental surgery provided in an outpatient hospital setting or by a freestanding ambulatory surgical center:
   a. intraoral complete series of x-rays, once every five years
   ~~b. scaling and root planning, once every two years;~~
   ~~c~~b.general anesthesia.

~~16~~17. House calls or extended care facility calls for on-site delivery of covered services

~~17~~18. Behavioral management when additional staff time is required to accommodate behavioral challenges and sedation is not used

10. Dental services.

18. Oral or IV sedation, if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center

D. Supervised dental services are provided by enrolled community health workers educating patients to promote good oral health and self-management of dental conditions.

E. Collaborative practice dental hygienist services are provided as designated in collaborative agreements with dentists who authorize and assume full professional responsibility for the services performed. Collaborative practice dental hygienist services may be performed without the presence of a dentist and may be performed at a location other than the usual place of practice of the dentist or dental hygienist and without a dentist's diagnosis and treatment plan, unless specified in the collaborative agreement.

Collaborative practice dental hygienist services are limited to:

1. Oral health promotion and disease prevention education;
2. Removal of deposits and stains from the surfaces of teeth;
3. Application of topical preventive or prophylactic agents, including fluoride varnishes and pit and fissure sealants;
4. Polishing and smoothing restorations;
5. Removal of marginal overhangs;
6. Performance of preliminary charting;
7. Taking of radiographs; and
8. Performance of scaling and root planning.

10. Dental services. (continued)

F. Dental therapist services are provided as designated in collaborative management agreements with dentists who authorize and assume full professional responsibility for the services performed.

Dental therapist services are limited to:

1. Services performed by a dental therapist licensed by the Minnesota Board of Dentistry and provided within the scope of practice of the dental therapist's license as identified in Minnesota law; and
2. The types of dental services described in paragraphs A, B and C of this item that are within the scope of the therapist's license as a dental therapist.

G. Advanced dental therapist services are provided as designated in collaborative management agreements with dentists who authorize and assume full professional responsibility for the services performed. Advanced dental therapist services may be performed without the presence of a dentist and may be performed at a location other than the usual place of practice of the dentist or advanced dental therapist and without a dentist's diagnosis and treatment plan, unless specified in the collaborative agreement.

Advanced dental therapist services are limited to:

1. Services performed by a therapist licensed and certified by the Minnesota Board of Dentistry and provided within the scope of practice of the advanced dental therapist's license as identified in Minnesota law; and
2. The types of services described in paragraphs A, B and C of this item that are within the scope of the therapist's license as an advanced dental therapist.

10. Dental services. (continued)

H. The following dental services are not eligible for payment for any recipient:

- Pulp caps
- Local anesthetic that is used in conjunction with a dental procedure and billed as a separate procedure
- Hygiene aids, including toothbrushes
- Medication dispensed by a dentist that a recipient is able to obtain from a pharmacy
- Acid etch for a restoration that is billed as a separate procedure
- Prosthesis cleaning
- ~~Removable unilateral partial denture that is a one-piece metal including clasps and teeth~~
- ~~Replacement of a denture when a reline or rebase would correct the problem.~~
- Duplicate x-rays
- Gold restoration, inlay or onlay, including nonprecious and semiprecious metals
- Dental services for cosmetic or aesthetic purposes

I. Critical access dental providers receive an increased payment pursuant to Attachment 4.19-B, item 10. The following providers who apply are granted critical access dental provider

1. Nonprofit community clinics that meet all of the following criteria:
   a. have nonprofit status in accordance with the Minnesota revenue law;
   b. have tax exempt status in accordance with 26 U.S.C. §501(c)(3);
   c. are established to provide oral health services to low income, uninsured, special needs, and underserved individuals;
   d. have staff familiar with the cultural background of the clinic's patients;

10. Dental services. (continued)

e) have a sliding fee scale based on current federal poverty income guidelines;
f) do not restrict access or services because of a patient's financial limitations or public assistance status; and
g) have free care available as needed.

2) Public health clinics;

3) A dental clinic or group owned and operated by a nonprofit corporation with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance or MinnesotaCare;

4) Dental clinics owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system;

5) County or city owned and operated hospital-based dental clinics;

6) Hospital-based dental clinics owned and operated by an essential community provider that was formerly a state hospital, and is now an outpatient hospital specializing in the treatment of cerebral palsy, spina bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling conditions; and

7) Private practicing dentists if:
a) the dentist's office is located within the seven-county metropolitan area and more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare ~~a health professional shortage area as defined under Code of Federal Regulations, title 42, part 5, and United States Code, title 42, section 254E~~; or
b) ~~more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare; and~~

~~c)~~ the dentist's office is located outside the seven-county metropolitan area and more than 25 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare.~~the level of service provided by the dentist is critical to maintaining adequate levels of patient access within the service area in which the dentist operates.~~

11. Physical therapy and related services.

See items 11.a. through 11.c.

11.a. Physical therapy services.

Coverage is limited to:

1) Services prescribed by a physician or other licensed practitioner of the healing arts within the scope of the practitioner's practice under state law.

2) Services provided by a physical therapist or services delegated by a physical therapist to a physical therapist assistant ~~who is under the direction of a physical therapist~~.

3) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician or other licensed practitioner of the healing arts at least once every ~~60~~90 days. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or the physician's delegate as required by Medicare.

4) Services that are:

A. Restorative therapy and are provided to a recipient whose functional status is expected by the physician or other licensed practitioner of the healing arts to progress toward or achieve the objectives in the recipient's plan of care within a ~~60~~90-day period; or

B. Specialized maintenance therapy is provided only to a recipient under 21 years of age. It is provided to a recipient whose condition cannot be maintained or treated only through rehabilitative nursing services or services of other care providers, or by the recipient because the recipient's medical condition(s) result in:

i. Spasticity or severe contracture that interferes with the recipient's activities of daily living or the completion of routine nursing care, or decreased functional ability compared to the recipient's previous level of function.

ii. A chronic condition that results in physiological deterioration and that requires specialized maintenance therapy services or equipment to maintain strength, range of motion, endurance, movement patterns, activities of daily living, cardiovascular function, integumentary status, positioning necessary for completion of the recipient's activities of daily living, or decreased abilities relevant to the recipient's current environmental demands, or;

11.a. Physical therapy services. (continued)

iii. health and safety risks for the recipient.

Specialized maintenance therapy must meet at least one of the following:

i. prevents deterioration and sustains function;

ii. for a chronic or progressive medical condition, provides interventions that enable a recipient to live at his or her highest level of independence; or

iii. provides treatment interventions for a recipient who is progressing but not at a rate comparable to the expectations of rehabilitative and therapeutic care.

Physical therapist is defined as an individual who is a graduate of a program of physical therapy ~~approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent~~ accredited by the Commission on Accreditation in Physical Therapy Education or its equivalent. Physical therapists must ~~meet~~ maintain applicable state licensure ~~requirements~~, or be in compliance with state regulatory requirements in states that do not license ~~when they are developed~~. Physical therapy services and providers must meet the requirements of 42 CFR § 440.110. Physical therapy services are provided by or under the ~~direction~~ supervision of a qualified physical therapist.

Physical therapist assistant is defined as ~~one qualified under the rules of the Board of Medical Examiners. These rules define a physical therapist assistant as~~ a skilled technical worker who is a graduate of a physical therapist assistant educational program accredited by the Commission on Accreditation in Physical Therapy Education or its equivalent ~~a comparable national accrediting agency approved by the Board~~. Physical therapist assistants must maintain applicable state licensure or be in compliance with state regulatory requirements in states that do not license. A physical therapist assistant performs selected physical therapy treatments and related duties as delegated by the physical therapist to assist the physical therapist in patient, client or resident related activities.

11. a. Physical therapy services. (continued)

~~**Direction**~~ **Delegation of duties** is defined as the actions of a physical therapist who ~~instructs~~ delegates to the physical therapist assistant ~~in~~ specific duties to be performed, monitors the provision of services on-site and documents the appropriateness of the services not less than every sixth treatment session, and meets the other supervisory requirements specified in law ~~the rules of the Board of Medical Examiners~~.

Coverage does not include:

1) Services provided in a nursing facility, ICF/MR, or day training and habilitation services center, if the cost of physical therapy has been included in the facility's per diem, such as:

   A. Services for contracture that are not severe and do not interfere with the recipient's functional status or the completion of nursing care as required for licensure of the long-term care facility;

   B. Ambulation of a recipient who has an established gait pattern;

   C. Services for conditions of chronic pain that does not interfere with the recipient's functional status and that can be maintained by routine nursing measures;

   D. Services for activities of daily living when performed by the therapist, therapy assistant or therapy aide; and

   E. Bowel and bladder retraining programs.

2) Arts and crafts activities for the purposes of recreation.

11.a. Physical therapy services. (continued)

3) Services that are not documented in the recipient's health care record.

4) Services that are not designed to improve, maintain, or prevent deterioration of the functional status of a recipient with a medical condition.

5) Services by more than one provider of the same type for the same diagnosis.

6) A rehabilitative and therapeutic service that is furnished by a provider not enrolled with Medicare, or, in the case of dual eligibles, furnished by a provider who does not first bill Medicare.

7) Evaluations or reevaluations performed by a physical therapist assistant.

8) Services provided by a physical therapist other than the therapist billing for the services, unless the physical therapist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case the agency, facility or physician must bill for the service.

9) For long-term care recipients, services for which there is not a statement every 30 days in the clinical record by the therapist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

11.b. Occupational therapy services.

Coverage is limited to:

1) Services prescribed by a physician or other licensed practitioner of the healing arts within the scope of the practitioner's practice under state law.

2) Services provided by an occupational therapist or services delegated by an occupational therapist to an occupational therapy assistant ~~who is under the direction of an occupational therapist~~.

3) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician or other licensed practitioner of the healing arts at least once every ~~60~~90 days. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or the physician's delegate as required by Medicare.

4) Services that are:
   A. Restorative therapy and are provided to a recipient whose functional status is expected by the physician or other licensed practitioner of the healing arts to progress toward or achieve the objectives in the recipient's plan of care within a ~~60~~90-day period; or

   B. Specialized maintenance therapy is provided only to a recipient under 21 years of age. It is provided to a recipient whose condition cannot be maintained or treated only through rehabilitative nursing services or services of other care providers, or by the recipient because the recipient's medical conditions(s) result in:

      i. Spasticity or severe contracture that interferes with the recipient's activities of daily living or the completion of routine nursing care, or decreased functional ability compared to the recipient's previous level of function;

11.b. Occupational therapy services. (continued)

ii. A chronic condition that results in physiological deterioration and that requires specialized maintenance therapy services or equipment to maintain strength, range of motion, endurance, movement patterns, activities of daily living, cardiovascular function, integumentary status, positioning necessary for completion of the recipient's activities of daily living, or decreased abilities relevant to the recipient's current environmental demands, or;

iii. Health and safety risks for the recipient.

Specialized maintenance therapy must meet at least one of the following:

i. prevents deterioration and sustains function;
ii. for a chronic or progressive medical condition, provides interventions that enable a recipient to live at his or her highest level of independence; or
iii. provides treatment interventions for a recipient who is progressing but not at a rate comparable to the expectations of rehabilitative and therapeutic care.

Occupational therapist is defined as an individual ~~certified by the National Board for Certification in Occupational Therapy~~ who maintains applicable state licensure or is in compliance with state regulatory requirements in states that do not license~~ as an occupational therapist~~. Occupational therapy services and providers meet the requirements of ~~43~~42 CFR 440.110. Occupational therapy services are provided by or under the ~~direction~~ supervision of a qualified occupational therapist.

Occupational therapy assistant is defined as an individual ~~who has successfully completed all academic and field work requirements of an occupational therapy assistant program approved or accredited by the Accreditation Council for Occupational Therapy Education and who~~ is currently certified by the National Board for Certification in Occupational Therapy as an occupational therapy assistant. Occupational therapy assistants must maintain applicable state licensure or be in compliance with state regulatory requirements in states that do not license.

11.b. Occupational therapy services. (continued)

~~**Direction**~~ **Delegation of duties** is defined as the actions of an occupational therapist who ~~instructs~~ delegates to the occupational therapy assistant ~~in~~ specific duties to be performed, ~~and~~ monitors the provision of services, and collaborates with the occupational therapy assistant face-to-face at least every two weeks ~~on-site and documents the appropriateness of the services not less than every sixth treatment session of each recipient~~.

Coverage does not include:

1) Services provided in a nursing facility, ICF/MR, or day training and habilitation service center, if the cost of occupational therapy has been included in the facility's per diem, such as:

   A. Services for contracture that are not severe and do not interfere with the recipient's functional status or the completion of nursing care as required for licensure of the long-term care facility;

   B. Ambulation of a recipient who has an established gait pattern;

   C. Services for conditions of chronic pain that does not interfere with the recipient's functional status and that can be maintained by routine nursing measures;

   D. Services for activities of daily living when performed by the therapist, therapy assistant or therapy aide; and

   E. Bowel and bladder retraining programs.

2) Arts and crafts activities for the purpose of recreation.

3) Services that are not documented in the recipient's health care record.

11.b. Occupational therapy services. (continued)

4) Services that are not designed to improve, maintain, or prevent deterioration of the functional status of a recipient with a medical condition.

5) Services by more than one provider of the same type for the same diagnosis.

6) A rehabilitative and therapeutic service that is furnished by a provider not enrolled with Medicare, or, in the case of dual eligibles, furnished by a provider who does not first bill Medicare.

7) Evaluations or reevaluations performed by an occupational therapy assistant.

8) Services provided by an occupational therapist other than the therapist billing for the service, unless the occupational therapist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case, the agency, facility or physician must bill for the service.

9) For long-term care recipients, services for which there is not a statement every 30 days in the clinical record by the therapist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).

Coverage of **speech and language therapy services** is limited to:

1) Services provided upon written referral by a physician or licensed practitioner of the healing arts within the scope of the practitioner's practice under state law, or, in the case of a resident of a long-term care facility, on the written order of a physician as required by 42 CFR §483.45.

2) Services provided by a speech language pathologist ~~or a person completing the clinical fellowship year required for certification as a speech-language pathologist under the supervision of a speech-language pathologist~~.

3) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician or other licensed practitioner of the healing arts at least once every ~~60~~90 days. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or the physician's delegate as required by Medicare.

4) Services that are:

A. Restorative therapy and are provided to a recipient whose functional status is expected by the physician or licensed practitioner of the healing arts to progress toward or achieve the objectives in the recipient's plan of care within a ~~60~~90-day period; or

B. Specialized maintenance therapy is provided only to a recipient under 21 years of age. It is provided to a recipient whose condition cannot be maintained or treated only through rehabilitative nursing services or services of other care providers, or by the recipient because the recipient's medical condition(s) result in:

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

i. Decreased functional ability compared to the recipient's previous level of function;

ii. Decreased abilities relevant to the recipient's current environmental demands; or

iii. Health and safety risks for the recipient.

Specialized maintenance therapy must meet at least one of the following:

i. prevents deterioration and sustains function;

ii. for a chronic or progressive medical condition, provides interventions that enable a recipient to live at his or her highest level of independence; or

iii. provides treatment interventions for a recipient who is progressing but not at a rate comparable to the expectations of rehabilitative and therapeutic care.

5) For long term care recipients, services for which there is a statement in the clinical record every 30 days that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

Speech pathology services and providers meet the requirements of 42 CFR 440.110. Speech pathology services are provided by or under the supervision ~~direction~~ of a qualified speech pathologist.

11.c. Speech, language; and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

Coverage of **speech-language therapy services** does *not* include:

1) Services that are not documented in the recipient's health care record.
2) Services by more than one provider of the same type for the same diagnosis unless the service is provided by a school district as specified in the recipient's individualized education plan.
3) Services that are furnished by a provider ~~eligible to enroll with Medicare, but~~ not enrolled with Medicare, or, in the case of dual eligibles, furnished by a provider who does not first bill Medicare.
4) Services that are provided without written referral.
5) Services not medically necessary.
6) Services that are not part of the recipient's plan of care.
7) Services provided in a nursing facility, ICF/MR or day training and habilitation services center if the cost of speech-language pathology has been included in the facility's per diem.
8) Services provided by a speech-language pathologist other than the pathologist billing for the service, ~~or a person completing the clinical fellowship year under the supervision of the pathologist,~~ unless the pathologist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case, the agency, facility or physician must bill for the service.
9) ~~Services provided by an independently enrolled speech language pathologist who does not maintain an office at his or her own expense.~~
10) ~~Services provided to dual eligibles by an independently enrolled speech-language pathologist.~~

Coverage of **hearing (audiology) therapy services** is limited to:

1) Services provided upon written referral by a physician or other licensed practitioner of the healing arts within the scope of the practitioner's practice under state law.

11. c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

2) Services provided by an independently enrolled audiologist who maintains an office at their own expense or an audiologist who is employed by and providing audiology services in a hospital, rehabilitation agency, home health agency, or clinic.

3) Services specified in a plan of care that is reviewed and revised as medically necessary at least once every ~~60~~90 days by the attending physician or other licensed practitioner of the healing arts. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or physician's delegate as required by Medicare.

4) Restorative therapy provided to a recipient whose functional status is expected by the physician or other licensed practitioner of the healing arts to progress toward or achieve the objectives in the recipient's plan of care within a ~~60~~90-day period.

5) For long term care recipients, services for which there is a statement in the clinical record every 30 days by the audiologist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

6) Services provided in the independent audiologist's own office, recipient's home, nursing facility, ICF/MR, or day training and habilitation services site.

Audiology services and providers meet the requirements in 42 CFR 440.110(c)(3). Audiology services are provided by or under the direction of a qualified audiologist.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

'Under the direction of a qualified audiologist' means that a federally qualified audiologist who is directing audiology services must supervise each beneficiary's care. To meet this requirement the qualified audiologist must, at a minimum, have face-to-face contact with the beneficiary initially and periodically as needed, be familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law, have continued involvement in the care provided, and review the need for continued services throughout treatment. The supervising audiologist must also assume professional responsibility for the services provided under their direction and monitor the need for continued services. The supervising audiologist must spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice. Moreover, the supervising audiologist must ensure that individuals working under their direction have contact information to permit them direct contact with the supervising audiologist as necessary during the course of treatment. In all cases, documentation must be kept supporting the supervision, provision of and claiming of services and ongoing involvement in the treatment. Absent appropriate service documentation, Medicaid payment for services may be denied providers.

Coverage of **hearing (audiology) therapy services** does *not* include:

1) Services that are not documented in the recipient's clinical record, even if the services were authorized by a physician.
2) Training or consultation provided by an audiologist to an agency, facility, or other institution.
3) Services provided by an audiologist other than the audiologist billing for the services, ~~or a person completing the clinical fellowship year under the supervision of the audiologist,~~ unless the audiologist provided the services in a hospital, rehabilitation agency, home health agency, or clinic, or as an employee of a physician or long-term care facility; in which case the contracting or employing facility, agency, or person must bill for the services.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

4) Services that are furnished by a provider not enrolled with Medicare, or in the case of dual eligibles, furnished by a provider who does not first bill Medicare.

Hearing aid services: After a physician rules out medical and surgical contraindictions, the physician refers the recipient for an audiologic evaluation. An audiologist or otolaryngologist provides audiologic testing, and if a hearing aid is indicated, prescribes a specific hearing aid offered under the hearing aid volume purchase contract or refers the recipient to a hearing aid services provider.

Payment is made to hearing aid services providers for hearing aids, dispensing fees, hearing aid repairs, accessories, ear molds when not provided with the hearing aid and batteries.

Coverage of **hearing aids** for adults is limited to:

1) Medically necessary ~~One~~ monaural and ~~or one set of~~ binaural hearing aids ~~within a period of five years unless prior authorized. A hearing aid will not be replaced when the recipient has received a replacement hearing aid twice within the five year period previous to the date of the request.~~

2) ~~Non-contract hearing aids require prior authorization.~~ No more than two replacement hearing aids due to loss, theft, or damage in the five years prior to the date of the request for a replacement.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

Coverage of **hearing aids** does *not* include:

1) Replacement batteries provided on a scheduled basis regardless of their actual need.
2) Services specified as part of the contract price when billed on a separate claim for payment. This includes any charges for repair of hearing aids under warranty.
3) Routine screening of individuals or groups for identification of hearing problems.
4) Separate reimbursement for postage, handling, taxes, mileage, or pick-up and delivery.
5) Nonelectronic hearing aids, telephone amplifiers, vibrating bed alarms, phone handsets, visual telephone ringers, swim molds, ear plugs, dry aid kits, and battery chargers.
6) Maintenance, cleaning; and checking of hearing aids, unless there has been a request or referral for the service by the person who owns the hearing aid, the person's family, guardian or attending physician.
7) Loaner hearing aid charges.
8) Canal type hearing aids.
9) A noncontract hearing aid that is obtained without prior authorization.
10) Services included in the dispensing fee when billed on a separate claim for payment.
11) Hearing aid services to a resident of a long-term care facility if the services did not result from a request by the resident, a referral by a registered nurse or licensed practical nurse who is employed by the long-term care facility, or referral by the resident's family, guardian or attending physician.
12) Hearing aid services prescribed or ordered by a physician if the physician or entity commits a felony listed in United States Code, title 42, section 1320a-7b, subject to the "safe harbor" exceptions listed in 42 CFR 1001.952.
~~13) Replacement of a lost, stolen or damaged hearing aid if MA has provided three hearing aids in the five years prior to the date of the request for a replacement.~~

12. Prescribed drugs, dentures, and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

See items 12.a. through 12.d.

12.a. Prescribed drugs.

The following providers are eligible for payment for dispensing prescribed drugs:

1. A pharmacy that is licensed by the Minnesota Board of Pharmacy.
2. An out of state pharmacy that complies with the licensing and certification requirements of the state in which it is located.
3. A physician located in a local trade area where there is no Medicaid enrolled pharmacy. To be eligible for payment, the physician shall personally dispense the prescribed drug according to applicable Minnesota Statutes and shall adhere to the labeling requirements of the Minnesota Board of Pharmacy.
4. A physician, physician assistant or nurse practitioner employed by or under contract with a community health board, for the purposes of communicable disease control.

The following limitations apply to pharmacy services:

1. The prescribed drug must be a drug or compounded prescription for which medical value has been established and that is made by a manufacturer that has a rebate with the Centers for Medicare & Medicaid Services (CMS) and included in the Minnesota Department of Human Services drug formulary. The formulary is established in accordance with §1927(d)(4) of the Social Security Act. See Drug Formulary.

   a) An "active pharmaceutical ingredient (API)" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing or packaging of a drug, becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredient and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:
      i. Is not a therapeutic option for the patient;
      ii. Does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and
      iii. Cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

12.a. Prescribed drugs. (continued)

2. A prescribed drug must be dispensed in the quantity specified on the prescription unless the pharmacy is using unit dose dispensing, the specified quantity is not available in the pharmacy when the prescription is dispensed, or the specified quantity exceeds a 34-day supply.

3. The dispensed quantity of a prescribed drug must not exceed a 34-day supply, unless authorized by the Department. Refill prescriptions for a 90-day supply of maintenance drugs in specific therapeutic classes identified by the Department may be dispensed without prior authorization. Contraceptive drugs may be dispensed in quantities ~~not exceeding a three-month~~ up to a 12-month supply ~~do not require~~ without prior authorization.

   Retrospective billing is a billing practice in which the pharmacy bills only for the quantity of medication actually used by the recipient during the retrospective billing cycle established by the pharmacy. A retrospective billing cycle must be between 30 and 34 days in length.

4. An initial or refill prescription for a maintenance drug shall be dispensed in not less than a 30-day supply unless the pharmacy is using unit dose dispensing, or is billing retrospectively for a quantity dispensed to a resident in a long-term care facility via unit dose or an automated dispensing system. No additional professional dispensing fee shall be paid until that quantity is used by the recipient. The pharmacy dispensing drugs to a resident in a long-term care facility must credit the state for the actual acquisition cost of all unused drugs that are eligible for reuse if the pharmacy Is not using a retrospective billing process.

5. Except as provided in item (6), coverage of the professional dispensing fee for a particular pharmacy or dispensing physician for a drug for a recipient is limited to one professional dispensing fee per 30- to 34-day supply, or 90 day supply as described in #3.

6. More than one professional dispensing fee per calendar month for a maintenance drug for a recipient is allowed if:

   a) the record kept by the pharmacist or dispensing physician documents that there is a significant chance of overdose by the recipient if a larger quantity of drug is dispensed, and if the pharmacist or dispensing physician writes a statement of this reason on the prescription; or
   b) the drug is clozapine.

12.a. Prescribed drugs. (continued)

7. A pharmacy dispensing an over-the-counter drug shall receive no more than one dispensing fee per claim and the dispensing fee shall be prorated if less than the manufacturer's original package size is dispensed. A pharmacy dispensing an over-the-counter drug shall receive no more than one dispensing fee per claim if dispensing multiple packages.

8. A refill of a prescription must be authorized by the practitioner. Refilled prescriptions must be documented in the prescription file, initialed by the pharmacist who refills the prescription, and approved by the practitioner as consistent with accepted pharmacy practice under Minnesota Statutes.

9. Generic drugs must be dispensed to recipients if:

   a) the generically equivalent drug is approved and is determined as therapeutically equivalent by the FDA;
   b) in the pharmacist's or dispensing physician's professional judgment, the generically equivalent drug is safely interchangeable with the prescribed drug;
   c) the charge for the substituted generically equivalent drug does not exceed the charge for the drug originally prescribed; and
   d) the practitioner has not written in his or her own handwriting "Dispense as Written-Brand Necessary" or "DAW-Brand Necessary" on the prescription, or indicated the medical necessity of a brand name drug using an electronic prescription. Effective January 2, 2004, even if the practitioner has indicated the medical need for a brand name drug, authorization is required to dispense brand name drugs.

10. The following limits apply to legend drugs dispensed under unit dose packaging:

    a) Dispensing fees for drugs dispensed in unit dose packaging shall not be paid more often than once per calendar month or when a minimum of 30 dosage units have been dispensed, whichever results in the lesser number of dispensing fees.
    b) Only one dispensing fee per calendar month will be paid for each maintenance drug, regardless of the type of unit dose system used or the number of times during the month the pharmacist dispenses the drug.
    c) An additional dispensing fee per prescription shall be paid to pharmacists using an in-pharmacy packaged unit dose system (except for over-the-counter medications) approved by the Board of Pharmacy for the return of drugs when dispensing to recipients in a long-term care facility if:

12.a. Prescribed drugs. (continued)

i. The pharmacy is registered with the Department by filing an addendum to the provider agreement;
ii. a minimum 30-day supply of the drug is dispensed, although a lesser quantity may be dispensed for an acute course of medication therapy for a specified time period;
iii. the national drug code from the drug stock container used to fill the unit dose package is identified to the Department;
iv. the unit dose package containing the drug meets the packaging standards set forth in Minnesota Statutes that govern the return of unused drugs to the pharmacy for reuse and documentation that unit dose packaging meets permeability standards of the Board of Pharmacy; and
v. the pharmacy provider credits the Department for the actual acquisition cost of all unused drugs that are eligible for return and reuse.

11. Delivery charges for a drug are not covered.

12. Medical assistance covers drugs purchased through the federal 340B drug pricing program by 340B covered entities and dispensed by 340B covered entities, and contract pharmacies owned by the 340B covered entity when the 340B contract pharmacy requests in writing and receives approval from the Department, to use these drugs for Minnesota Medicaid beneficiaries. Drugs acquired through the federal 340B drug pricing program and dispensed by other 340B contract pharmacies are not covered.

13. Drugs that are considered investigational, drugs that are provided to a recipient during the clinical trial designed to test the efficacy of the provided drug, or drugs that have not been approved for general use by the U.S. Food and Drug Administration are not covered. ~~The Department covers stiripentol as a specialty pharmacy product for children with certain medical conditions.~~

Drug Formulary:

All drugs and compounded prescriptions made by a manufacturer that are covered under a signed rebate agreement with CMS are included in the drug formulary, with the following limitations on coverage:

Over-the-counter drugs must be listed in the Department's "Health Care Programs Provider Manual,." ~~on a remittance~~

12.a. Prescribed drugs. (continued)

advice message, or in a Department-issued provider update. The following over-the-counter drugs are covered only when prescribed by a licensed practitioner or a licensed pharmacist who meets standards established by the Department, in consultation with the Board of Pharmacy:

a) antacids;
b) acetaminophen;
c) aspirin;
d) family planning products;
e) insulin;
f) products for the treatment of lice;
g) vitamins for adults with documented vitamin deficiencies;
h) vitamins for children under the age of seven and pregnant or nursing women; and
i) any other drug identified by the Department, in consultation with the Drug Formulary Committee.

1. The following categories of drugs are not covered pursuant to §1927(d)(2):

~~a) Drugs or active pharmaceutical ingredients used for weight loss, except that medically necessary lipase inhibitors may be covered for recipients with type 2 diabetes.~~

~~b~~a) Agents or active pharmaceutical ingredients when used to promote fertility.

~~c~~b) Agents or active pharmaceutical ingredients when used for cosmetic purposes or hair growth.

~~d~~c) Covered outpatient drugs that the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

~~e~~d) Drugs described in §107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of 21 CFR §310.6(b)(1) (DESI drugs)).

~~f~~e) Drugs or active pharmaceutical ingredients for which medical value has not been established.

12.a. Prescribed drugs. (continued)

2. The following categories of drugs are covered with limitations pursuant to §1927(d)(2):

   ~~a)~~ Agents when used for the symptomatic relief of cough and colds must be listed in the Department's "Minnesota Health Care Programs Provider Manual~~,~~." ~~on a remittance advice message, or in a Department-issued provider update.~~

   b) Prescription vitamins and mineral products for children, pregnant and nursing women, and recipients with documented vitamin deficiencies. The limitations do not apply to fluoride treatments. Prenatal vitamins are restricted to pregnant and nursing women.

3. Medicaid does not cover drugs or active pharmaceutical ingredients when used for the treatment of sexual or erectile dysfunction. Sexual or erectile dysfunction drugs and active pharmaceutical ingredients are covered when used for the treatment of other conditions or indications approved by the FDA.

4. Medicaid will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

12.a. Prescribed drugs. (continued)

Prior Authorization:

A. The following requirements, found in §1927(d)(5) of the Act, are met:

- The prior authorization program provides a response by telephone or other telecommunication device within 24 hours of a request.
- The prior authorization program provides for the dispensing of at least a 72-hour supply of a covered drug in an emergency situation (except for those drugs that are excluded or restricted from coverage, as noted above).

B. Prior authorization, for a period of not more than 180 days, may automatically be required for drugs approved by the FDA on or after July 1, 2005. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within Minnesota. The Department's Drug Formulary Committee will establish general authorization criteria to be used during the 180-day period.

C. Based on the requirements in §1927, the State has the following policies for the supplemental drug rebate program for Medicaid recipients:

1. CMS has authorized the State of Minnesota to enter into the Michigan Multi-State Pooling Agreement (MMSPA) also referred to as the National Medicaid Pooling Initiative (NMPI) for drugs provided to Medicaid beneficiaries. The NMPI Supplemental Rebate Agreement (SRA) and the amendment to the SRA submitted to CMS on April 30, 2004 have been authorized for pharmaceutical manufacturers' existing agreements through their current expiration dates. The updated NMPI SRA effective for ~~January 1, 2017~~July 1, 2019, has been authorized for renewal and new agreements with pharmaceutical manufacturers for drugs provided to Medicaid beneficiaries.
2. Supplemental drug rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national drug rebate agreement.
3. Manufacturers with supplemental rebate agreements are allowed to audit utilization data.

12a. Prescribed drugs (continued)

4. The unit rebate amount is confidential and will not be disclosed except in accordance with §1927(b)(3)(D) of the Act.
5. A drug that the Department determines comes within its multi-state supplemental drug rebate program for Medicaid recipients as allowed by §1927, but for which a manufacturer has not signed a supplemental drug rebate agreement authorized by CMS, will be prior authorized.

   Even if a manufacturer has not signed a supplemental drug rebate agreement, there is never prior authorization for any atypical antipsychotic drug prescribed for the treatment of adult mental illness if:
   - there is no generically equivalent drug available; and
   - the drug was initially prescribed for the recipient before July 1, 2003; or
   - the drug is part of the recipient's current course of treatment.

Medicaid covers the following prescribed drugs not eligible for rebate:

- vitamins for adults with documented vitamin deficiencies
- vitamins for children under the age of seven and pregnant or nursing women

The State may enter into value-based contracts with manufacturers on a voluntary basis. These contracts will be executed on the model agreement entitled "Value-Based Supplemental Rebate Agreement" authorized for use beginning April 1, 2024.

12.b. Dentures.

A Removable unilateral partial denture that is a one-piece metal including clasps and teeth is not eligible for payment for any recipient.

Medically necessary denture services for children under 21 years of age are covered in accordance with EPSDT requirements as described in section 1905(r) of the Social Security Act.

The reline or rebase of a removal denture is covered for all recipients.

For pregnant women:

- Initial placement or replacement of removable dentures is limited to one time every three years for a recipient unless the dentures are misplaced, stolen or damaged due to circumstances beyond the recipient's control, or the dentures cannot be modified or altered to meet the client's dental needs.

- ~~Replacement of dentures less than three years old requires prior authorization.~~

- The payment rate for dentures includes instruction for the use and care of the dentures and any adjustment necessary during the first six months immediately following the provision of the dentures.

- Coverage does not include denture replacement if a reline, rebase or repair would correct the problem.

For adults other than pregnant women:

- ~~Removable partial and full dentures are limited to one appliance per dental arch every six years.~~
- Initial placement or replacement of removable dentures is limited to one time every six years for a recipient unless the dentures are misplaced, stolen or damaged due to circumstances beyond the recipient's control, or the dentures cannot be modified or altered to meet the client's dental needs.

- The payment rate for dentures includes ~~payment for~~ instruction for ~~on~~ the use and care of the dentures and any adjustment necessary during the first six months immediately following the provision of the dentures.

- Coverage does not include denture replacement if a reline, rebase or repair would correct the problem.

12.c. Prosthetic devices.

- Prosthetic or orthotic devices means replacement, corrective or supportive devices for the purpose of artificially replacing a missing portion of the body or to prevent or correct physical deformity or real function or to support a weak or deformed part of the body.

- Prosthetic or orthotic devices are eligible for payment with the following limitation:

  - Ambulatory aid must be prescribed by a physician who is knowledgeable in orthopedic or physiatrics, or by a physician in consultation with an orthopedist, physiatrist, physical therapist, or occupational therapist, or by a podiatrist.

- The following prosthetic or orthotic devices and repairs are not eligible for payment:

  1) A device for which Medicare has denied the claim as not medically necessary;
  2) A device that is not medically necessary for the recipient;
  3) A device, other than a hearing aid, that is provided to a recipient who is an outpatient or resident of a long-term care facility and this is billed directly to medical assistance except as in item 7.c., Medical Supplies, Equipment and Appliances;
  4) Repair of a rented device;
  5) Repair of a device if the repair is covered by warranty;
  6) Routine, periodic service of a recipient's device owned by a long-term care facility;
  7) A device that has as a purpose to serve as a convenience to a person caring for the recipient;
  8) A device that is not received by the recipient;
  9) A device that serves to address social and environmental factors and that does not directly address the recipient's physical or mental health; and
  10) A device not supplied by a medical supplier.

12.d. Eyeglasses.

- Comprehensive vision examinations and intermediate vision examinations are eligible for payment.

- Medically necessary eyeglasses are specifically defined.

- Eyeglasses which have been lost, stolen, or irreparably damaged must be an identical replacement.

- Payment will be made for a new pair of eyeglasses for:

  1) A change in the recipient's head size.
  2) A change in eyeglasses that are medically necessary ~~mandated by medical necessity.~~
  3) An allergic reaction to the eyeglass material.
  4) A prescription change of .5 diopter or greater.

- The following eyeglasses or ~~eyeglass~~ vision services are not covered:

  1) Cosmetic services.
  2) Contact lenses prescribed for reasons other than aphakia, keratoconus, aniseikonia, marked acuity improvement over correction with eyeglasses, or bandage lenses.
  3) Dispensing services related to a noncovered service.
  4) Replacement of lenses or frames to change the style or color.
  5) Fashion tints and polarized lenses, unless medically necessary.
  6) Protective coating for plastic lenses.
  7) Edge and anti-reflective coating of lenses.
  8) Industrial or sport eyeglasses, unless they are the recipient's only pair and are necessary for vision correction.
  9) Eyeglasses, lenses, or frames that are not medically necessary.
  10) Invisible bifocals or progressive bifocals.

12.d. Eyeglasses. (continued)

11) An eyeglass service for which a required prior authorization was not obtained.

12) Replacement of lenses or frames due to provider error in prescribing, frame selection, or measurement. The provider making the error is responsible for bearing the cost of correcting the error.

13) Services or materials that are considered to be experimental or nonclinically proven by prevailing community standards or customary practice.

14) Eyeglass repair during the warranty period if the repair is covered by warranty.

15) Backup eyeglasses.

16) Photochromatic lenses, except for a recipient who has a diagnosis of albinism, achromatopsia, aniridia, blue cone monochromastism, cyctinosis, or retinitis pigmentosa, or any other condition for which such lenses are medically necessary.

~~17) Transition lenses unless medically necessary.~~

~~18) High index plastic lenses.~~

~~19)~~ Eyeglasses or lenses for occupational or educational needs, unless it is the recipient's only pair and are necessary for vision correction.

18. Purchase of eyeglass frames or lenses not covered by a contract obtained through the competitive bidding process.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

See items 13.a. through 13.d.

13.a. Diagnostic services.

- Must be medically necessary, the least expensive, appropriate alternative, and delivered by an enrolled MA provider.

13.b. Screening services.

- Must be medically necessary, the least expensive, appropriate alternative, and delivered by an enrolled MA provider.

13.c. Preventive services.

- Preventive services are health services provided to a recipient to avoid or minimize the occurrence or recurrence of illness, infection, disability, or to provide care for pregnancy.

- Services must be provided to the recipient on a face-to-face basis.

- The services must affect the recipient's care rather than the recipient's environment.

- The service must not be otherwise available to the recipient without cost as part of another program funded by a government or private agency.

- The service must not be part of another covered service.

- The service must be to avoid or minimize an illness, infection, or disability which will respond to treatment.

- The service must be generally accepted by the provider's professional peer group as a safe and effective means to avoid or minimize the illness, infection, or disability.

- Prior authorized cardiac rehabilitation services are covered preventive services with the following limitations:

  1) The services must be defined services whereby a physician is on the premises of the active program at all times in which the facility is opened.

  2) The services must be conducted in an area set aside for the exclusive use of the program while it is in session.

  3) The service must be a Medicare approved cardiac rehabilitation program.

13.c. Preventive services. (continued)

- The following services may be offered within the cardiac program as a covered service:

  1) diagnostic testing - stress testing;

  2) ECG monitoring;

  3) other reasonable and necessary diagnostic services;

  4) psychotherapy,

  5) exercise therapy.

- The following cardiac rehabilitation services are not eligible for payment:

  1) services provided without the direct on premises supervision of a physician;

  2) physical therapy and occupational therapy in connection with a cardiac rehabilitation program unless there is also a diagnosis of a non-cardiac condition requiring such therapy;

  3) patient education.

- The following preventative services are not eligible for payment:

  1) service that is only for a vocational purpose or an educational purpose that is not health related; and

  2) service dealing with external, social, or environmental factors that do not directly address the recipient's physical or mental health.

13.c. Preventive services. (continued)

The following are preventive services covered without cost-sharing:

Any clinical preventive services that currently have a rating of A or B from the United States Preventive Services Task Force (USPSTF).

Approved immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention, and their administration.

Changes to ACIP recommendations are incorporated into coverage and billing codes as necessary to comply with revisions.

13.d. Rehabilitative Services

Rehabilitative services are limited to:

(1) Except as otherwise noted, services provided under the recommendation of a physician. The therapeutic treatment must be a part of the recipient's plan of care; and
(2) Services that are medically necessary and the least expensive, appropriate alternative.

Mental health rehabilitative services are the following:

- Community mental health center (CMHC) services provided by a facility that meets the requirements of applicable state law. ~~Minnesota Statutes §256B.0625, subdivision 5~~

- The CMHC must be ~~licensed~~ certified as a mental health clinic under applicable state law ~~Minnesota Rules, parts 9520.0750 to 9520.0870~~. The CMHC must ~~to~~ provide mental health services under the ~~clinical supervision~~ oversight of a mental health professional who is ~~licensed for independent practice at thedoctoral level, or a psychiatrist who is eligible for board certification~~a doctoral level psychologist or a board certified or board eligible psychiatrist. ~~A CMHC's mental health team includes at least a:~~

~~1. Licensed physician who has completed an approved residency program in psychiatry;~~

~~2. doctoral clinical, counseling, or health care psychologist; and~~

~~3. clinical social worker with a master's degree in social work from an accredited college or university and/or a clinical psychiatric nurse with a master's degree in psychiatric nursing or a related psychiatric nursing program from an accredited college or university.~~

A CMHC's mental health team must include mental health professionals as described in item 6.D.A. A CMHC's mental health team may include clinical trainees as described in item 6.D.A as well as ~~As needed, the mental health team may also consist of~~ other professionals, paraprofessionals and disciplines. Staff qualifications are consistent with the specific service listed, below.

CMHC services are furnished by a private nonprofit corporation or a governmental agency that has a

13.d. Rehabilitative services. (continued)

community board of directors. Providers must be capable of providing the services to recipients who are diagnosed with both mental illness or emotional disturbance and chemical dependency, and to recipients dually diagnosed with a mental illness or emotional disturbance and developmental disability.

The following are included in the **CMHC services** payment:

1. Diagnostic assessment
2. Explanation of findings
3. Family, group and individual psychotherapy, including crisis intervention psychotherapy services, multiple family group psychotherapy, psychological testing, and medication management
4. Adult day treatment services provided as described below.
5. Professional home-based mental health services
6. For Medicare-certified centers, partial hospitalization for mental illness, as defined at §1861(ff) of the Act
7. Neuropsychological services provided as described below.

Adult day treatment includes at least one hour of group psychotherapy and must include group time focused on rehabilitative interventions or other therapeutic services that are provided by a multidisciplinary staff. Rehabilitative interventions are linked to goals and objectives identified in an individual's treatment plan which will lead to improvement in functioning that has been impaired by the symptoms of individual's mental illness or emotional disturbance. Other therapeutic services may include such services as harm reduction or cognitive behavior therapy. Coverage is limited to services provided up to 15 hours per week.

Individual members of the adult day treatment multidisciplinary team must meet, at a minimum, the standards for a mental health practitioner that apply to adult rehabilitative mental health services as defined in this item. Members of the multidisciplinary team provide only those day treatmentservices that are within their scope of practice.

The following agencies may apply to become adult day treatmentproviders:

- Licensed outpatient hospitals with JCAHO accreditation;
- MHCP-enrolled community mental health centers; or
- Entities under contract with a county to operate a day treatment program.

Neuropsychological services include neuropsychological assessment and neuropsychological testing.

13.d. Rehabilitative services. (continued)

Eligible providers of clinical neuropsychological services must meet one of the following:

- Have a diploma from one of the following:
  - American Board of Clinical Neuropsychology (ABCN)
  - American Board of Professional Neuropsychology (ABPN)
  - American Board of Pediatric Neuropsychology (ABPdN)

- Have been enrolled as an eligible provider of neuropsychological assessment prior to December 31, 2010;

- Earned a doctoral degree in psychology from an accredited university training program:
  1. completed an internship, or its equivalent, in a clinically relevant area of professional psychology;
  2. completed the equivalent of two full-time years of experience and specialized training, at least one which is at the postdoctoral level, in the study and practices of clinical neuropsychology and related neurosciences supervised by a clinical neuropsychologist or
  3. have been credentialed by another state's board of psychology examiners in the specialty of clinical neuropsychology utilizing equivalent requirements to those specified by one of the above-named Boards.

~~**Telemedicine services. CMHC services**, except adult day treatment services and partial hospitalization for mental illness, that are otherwise covered as direct face-to-face services may be provided via two way, interactive video if medically appropriate to the condition and needs of the recipient.~~

The community mental health center must provide 24-hour emergency care or demonstrate the capacity to assist recipients in need of such services on a 24-hour basis.

13.d. Rehabilitative services. (continued)

- **Community health worker services** are recommended by a mental health professional defined in item 6.d.A. after a diagnostic assessment. They provide culturally relevant patient education and care coordination services pursuant to an individual treatment plan, written by a mental health professional or by a mental health practitioner under the clinical supervision of a mental health professional.

- **Adult rehabilitative mental health services (ARMHS)** are recommended by a mental health professional defined in item 6.d.A. after a diagnostic assessment and a functional assessment. They are provided pursuant to an individual treatment plan, written by a mental health professional or by a clinical trainee or mental health practitioner under the clinical supervision of a mental health professional. The services are provided on a one-to-one basis or in a group in a recipient's home, a relative's home, school, place of employment, or other community setting.

Adult rehabilitative mental health services are provided by:

1. A county-operated or non-county operated entity certified by the Department.

2. A facility of the Indian Health Service or a facility owned or operated by a tribe or tribal organization and funded by either Title I of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, or Title I of the Indian Self Determination and Education Assistance Act, P.L. 106-260, operating as a 638 facility.

13.d. Rehabilitative services. (continued)

Provider Qualifications and Training

1. A mental health practitioner must be qualified in at least one of the following ways:

A. has completed coursework in of the behavioral sciences or related fields equal to 30 semester hours or 45 hours under a quarters system, and one of the following:

(i) has at least 2,000 hours of supervised experience in the delivery of services to:

1) persons with mental illness, emotional disturbance, or substance use disorder; or

2) persons with traumatic brain injury or developmental disabilities, and completes Department .required training on mental illness;

(ii) is fluent in the non-English language of the ethnic group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to persons with mental illness or emotional disturbance, and receives ~~clinical~~ supervision from a mental health professional at least once a week until the requirement of 2,000 hours of supervised experience is met;

(iii) works in a day treatment program; or

(iv) has completed a practicum or internship that required direct interaction with clients and was focused on behavioral sciences or a related field.

B. has at least 4,000 hours of supervised experience in the delivery of services to persons with mental illness, emotional disturbance, or substance use disorder; a practitioner with 2,000 hours of supervised experience must receive weekly supervision from a mental health professional until he or she has 4,000 hours of supervised experience;

C. has at least 4,000 hours of supervised experience in the delivery of services to clients with traumatic brain injury or developmental disabilities, and completes Department required training on mental illness. A practitioner with 2,000 hours of supervised experience must receive weekly supervision from a mental health professional until he or she has 4,000 hours of supervised experience;

D. is a graduate or undergraduate student in one of the behavioral sciences or related fields and is formally assigned by an accredited college or university to an agency or facility for clinical training;

13.d. Rehabilitative services. (continued)

E. holds a master's or other graduate degree in one of the behavioral sciences or related fields from an accredited college or university
F. holds a bachelor's degree in one of the behavioral sciences or related fields, and completes a practicum or internship that requires direct interaction with clients and is focused on behavioral sciences or a related field; or

A mental health practitioner must receive ongoing continuing education training ~~as required by the practitioner's professional license; or, if not licensed, a mental health practitioner must receive ongoing continuing education training~~ of at least 30 hours every two years in areas of mental illness and mental health services.

2. A mental health rehabilitation worker must:

A. Be at least ~~21~~18 years of age;
B. Have a high school diploma or equivalent;
C. Have successfully completed 30 hours of training before provision of direct services, or during the two years immediately prior to the date of hire, in all the following areas: recovery from mental illness/emotional disturbance, mental health de-escalation techniques, recipient rights, recipient-centered individual treatment planning, behavioral terminology, mental illness/emotional disturbance, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, and recipient confidentiality; and
D. Meet the qualifications in (1), (2) or (3)below:
(1)
(a) have an associate of arts degree; ~~or~~
(b) completed a two-year full-time, post-secondary educationin one of the behavioral sciences or human services;
(c) completed coursework in one of the behavioral sciences or related fields equal to 15 semester hours or 23 hours under a quarters system;
(d) be a registered nurse~~,~~ or
(e) within the previous ten years:
(i) have three years of personal life experience with serious mental illness;
(ii) have three years of life experience as a primary caregiver to a person with a serious mental illness/emotionaldisturbance, substance use disorder, developmental disability, or traumatic brain injury; or
(iii) have 2,000 hours of supervised work experience in the delivery of mental health services topersons with serious mental illness/emotional disturbance, substance use disorder, developmental disability, or traumatic brain injury; or

13.d. Rehabilitative services. (continued)

(2) (a) Be fluent in the language or competent in the cultureof the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong;

(b) receive monthly individual ~~clinical~~ supervision by amental health professional during the first 2,000 hours ofwork. Supervision must be documented;

(c) receive direct observation by a mental health professional, clinical trainee, or mental health practitioner twice per month for the first six months of employment and once per month thereafter. ~~have 18 hours of documented field supervision by a mental health professional or mental health practitioner during the first 160 hours of contact work with recipientsand at least six hours of field supervision quarterly during the following year~~;

(d) have review and ~~cosignature of charting of recipientcontacts~~ approval of progress notes made for services during ~~field supervision~~ direct observation by a mental health professional, clinical trainee or mental health practitioner; and

~~(e) have 15 hours of additional continuing education onmental health topics during the first year of employmentand 15 hours during every additional year of employment.Or,~~

~~(3) For providers of intensive residential treatment services orcrisis stabilization services in a residential setting, meet the qualifications described below:~~

~~(a) Meet the requirements of clause 2(b) - (d) above; and(b) Have 40 hours of additional continuing education on mental health topics during the first year of employment;~~

~~A. Receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness/emotional disturbanceand mental health services and other areas specific to the population being served.~~

13.d. Rehabilitative services. (continued)

3. **Certified Peer Specialist:**

A. **Certified Peer Specialist Level** I must:

1. Be at least ~~21~~18 years of age;
2. ~~Have a high school diploma or equivalent,~~
3. Have had a primary diagnosis of mental illness;
4. Be a current or former consumer of mental health services;
5. Successfully complete peer specialist certification training, approved by the Department of Human Services that teaches specific skills relevant to providing peer support to other consumers.

B. **Certified Peer Specialist Level II** must:

1. Meet all of the qualifications of a Certified Peer Specialist Level I and;
2. Meet one of more of the following:
   a. Be qualified at the Mental Health Practitioner level as defined in section 4.b;
   b. Have at least 6,000 hours of supervised experience in the delivery of peer services to persons with mental illness;
   c. Have at least 4,000 hours of supervised experience in the delivery of services to persons with mental illness and an additional 2,000 hours of supervised experience in the delivery of peer services to persons with mental illness.

C. ~~**Certified Peer Specialists Level I and II** must:~~

~~1. Receive documented monthly individual clinical supervision by a mental health professional during the first 2,000 hours of work;~~
~~2. Have 18 hours of documented field supervision by a mental health professional or mental health practitioner during the first 160 hours of contact work with recipients and at least six hours of field supervision quarterly during the following year;~~
~~3. Have review and co-signature of charting of recipient contacts during field supervision by a mental health professional or mental health practitioner; and~~
~~4. Complete continuing education training of at least 30 hours every two years in areas of recovery, rehabilitative services and peer support.~~

13.d. Rehabilitative services. (continued)

5. A clinical trainee is defined according to 6.d.A

For the purposes of adult rehabilitative mental health services, a mental health professional is defined in item 6.d.A. Except for the provision of diagnostic assessments, a mental health professional also includes a nationally certified provider who has:

(1) a master's degree from an accredited college or university in behavioral sciences or related fields;
(2) at least 4,000 hours of post-master's supervised experience providing mental health services to clients; and
(3) a valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner.

A clinical trainee, mental health practitioner, certified peer specialist, or mental heath rehabilitation worker must have at least 30 hours of continuing education every two years, as described by state law.

A clinical trainee, mental health practitioner, certified peer specialist, or mental heath rehabilitation worker must perform all services described under the supervision of a mental health professional and have a written treatment supervision plan, developed within 30 days of employment and updated annually.

6. An Occupational Therapist, as described in item 11.b.

13.d. Rehabilitative services. (continued)

~~**Components of Mental Health Community Support Services**~~

Adult rehabilitative mental health services (ARMHS) are comprised of the following six component services. ~~A mental health professional, a mental health practitioner under the clinical supervision of a mental health professional,~~ and a certified peer specialist II under the ~~clinical supervision of a mental health professional are qualified to provide components 1 – 5. A~~ a mental health rehabilitation worker under the ~~direction of a mental health professional, or a mental health practitioner and under the clinical supervision of a mental health professional must be capable of providing the following three components is qualified to provide components 3 – 5. A certified peer support specialist I under the clinical supervision of a mental health professional is qualified to provide peer support (component 5) services only.~~

~~A mental health professional means an individual defined in item 6.d.A. or an individual who: 1) has a master's degree from an accredited college or university in one of the behavioral sciences orrelated fields, with at least 4,000 hours of post-master's supervisedexperience in the delivery of clinical services in the treatment of mental illness; and 2) holds a current and valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner.~~

The qualifications for a clinical trainee, mental health practitioner, a certified peer specialist, and a mental health rehab worker are previously describedin this item.

1. Functional assessment: A functional assessment is provided by a mental health professional, clinical trainee, or mental health practitioner. A complete **functional assessment** consists ofthe following two component:
   a. The **assessment of functional ability** is a narrative that identifies and describes:
      - the person's functional strengths and deficits;
      - the person's current status within each life area domain; and
      - the linkage between the individual's mental illness and their status and level of functioning within each life area domain.
   b. The assessment of functional ability informs the **level of care assessment,** which determines the service intensity needs of the individual.

2. Individualized treatment plan: An individualized treatment plan is provided by a mental health professional, clinical trainee, or mental health practitioner. A treatment plan is based on a diagnostic and functional assessment, documents the plan of care and guides treatment interventions. Development of the treatment plan includes involvement of the client, client's family, caregivers, or other persons, which may include persons authorized to consent to mental health services for the client, and includes arrangement of treatment and support activities consistent with the client's cultural and linguistic needs.

13.d. Rehabilitative services. (continued)

3. Basic living and social skills are provided by any of the staff types listed above, ~~which~~ and may include:

a. Communication skills.
b. Social skills
c. Budgeting and shopping skills.
d. Healthy lifestyle skills.
e. Household management skills.
f. Transportation skills.
g. Medication monitoring.
h. Crisis assistance skills, including relapse prevention skills ~~.~~

4. Community intervention is provided by any of the staff types listed above, and is the consultation with relatives, guardians, friends, employers, treatment providers, and other significant people. Community intervention enables the recipient to retain stability, function in the community, and reduces the risk of significant decompensation or theneed to move to a more restrictive setting. The intervention must be directed exclusively to the treatment of the recipient.

5. Certified Peer Specialist support is provided by a certified peer specialist I or II, ~~which~~ and must include:

i. Non-clinical peer support that is person-centered and recovery-focused;
j. Promoting recipient ownership of the plan of care to ensure the plan reflects the needs and preferences of the recipient in achieving specific, measurable results;
k. Assisting the recipient with specific, recovery-focused activities designed to promote empowerment, self-determination and decision-making to help the recipient achieve personal wellness and cope with the stressors and barriers encountered when recovering from their disability;
l. Participating as a fully integrated mental health team member who provides highly individualized services in the community and shares the experience of mental health consumers and consumer culture to inform the team.
m. Providing a level of Certified Peer Specialist support determined on an individual basis taking into account the intensity of the situation, the knowledge base of the Certified Peer Specialist and the acuity of the beneficiary's condition.

13.d. Rehabilitative services. (continued)

6. A ~~—~~Medication education is provided by a physician, physician assistant, pharmacist ~~and~~ or registered nurse~~ must be capable of providing medication education~~. Medication education includes training the recipient in the symptoms of mentalillness, discussing the benefits and side effects of psychotropic medication, and discussing the importance of medication compliance.Medical education enables the recipient to better manage the symptoms of mental illness, allowing the recipient to return to independent functioning with less chance of relapse.

The services below are not eligible for medical assistance payment as adult rehabilitative mental health services:

1. Recipient transportation services.
2. Services billed by a nonenrolled Medicaid provider.
3. Services provided by volunteers.
4. Direct billing of time spent "on call" when not providing services.
5. Job-specific skills services, such as on-the-job training.
6. Performance of household tasks, chores, or related activities forthe recipient.
7. Provider service time paid as part of case management services
8. Outreach services, which means services identifying potentially eligible people in the community, informing potentially eligible people of the availability of adult rehabilitative mental health services, and assisting potentially eligible people with applying for these services.
9. Services provided by a hospital, board and lodge facility, or residential facility to patients or residents. This includes services provided by an institution for mental disease.

13.d. Rehabilitative services. (continued)

Mental health crisis response services are services recommended by a physician, mental health professional defined in item 6.d.A, or licensed mental health practitioner. Mental health crisis response services may be provided by the following provider types:

1. A county-operated or non-county operated entity certified by the Department.
2. A facility of the Indian Health Service or a facility owned or operated by a tribe or tribal organization and funded by either Title I of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, P.L. 106-260, operating as a 638 facility.

Mental health crisis team members must meet the qualifications, training and supervision standards that apply to adult rehabilitative mental health services in addition to completing at least 30 hours of training in crisis response services skills and knowledge every two years. Members of the team provide only those crisis services that arewithin their scope of practice, and under the supervision required by state law.

The components of mental health crisis response services are:

1. **Crisis assessment.** Crisis assessment is an immediate face-to-face appraisal by a physician, mental health professional, clinical trainee, or mental health practitioner ~~under the clinical supervision of a mental health professional~~, following a following a determination that suggests the recipient may be experiencing a mental health crisis.

   The crisis assessment is an evaluation of any immediate needs for which emergency services are necessary and, as time permits, the recipient's life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning.

2. **Crisis intervention.** Crisis intervention is a face-to-face, short-term intensive service provided during a mental health crisis to help a recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning. Crisis intervention must be available 24 hours a day, seven days a week. However, if a county provider demonstrates to the satisfaction of the Department that, due to geographic or other barriers, it cannot provide crisis intervention'24 hours a day, seven days a week, the Department may approve a county provider based on an alternative plan proposed by a county or group of counties. The alternative plan must be designed to:

   1) result in increased access and reduction in disparities in the availability of crisis services;

13.d. Rehabilitative services. (continued)

and 2) provide mobile services outside of normal businesshours and on weekends and holidays.

A. Crisis intervention is provided after the crisisassessment.
B. Crisis intervention includes developing a crisis treatment plan. The plan must include recommendations for any needed crisis stabilization services. It must be developed no later than 24 hours after the first face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided. The plan must be updated as needed to reflect current goals and services.

   The crisis intervention team must document which short-term goals were met, and when no further crisis intervention services are required.
C. The crisis intervention team is comprised of at least two mental health professionals, or a combination of atleast one mental health professional and one mental health practitioner or clinical trainee with the required crisis training and ~~under the clinical~~ supervision ~~of a mental health professional on the team~~. The team must have at least two members, with at least one member providing on-site crisis intervention services when needed.
D. If possible, at least two members must confer in personor by telephone about the assessment, crisis treatmentplan, and necessary actions taken.
E. If a recipient's crisis is stabilized, but the recipientneeds a referral to other services, the team must provide referrals to these services.

2. Crisis stabilization. Crisis stabilization is an individualized mental health service designed to restore a recipient to the recipient's prior functional level.

~~A. Crisis stabilization cannot be provided without firstproviding crisis intervention.~~
B. Crisis stabilization is provided by a mental health

13.d. Rehabilitative services. (continued)

professional, a clinical trainee, a mental health practitioner who is under theclinical supervision of a mental health professional, or a mental health rehabilitation worker or certified peer specialist who meets the qualifications on pages 53c - 53d.1, who works under the direction of a mental health professional or a mental health practitioner, and works under the clinical supervision of a mental health professional.

C. Crisis stabilization may be provided in the recipient's home, another community setting, or a supervised, licensed residential program (that is not an IMD) that provides short-term services. Stays in excess of 10 days in a month require authorization from the Department. If provided in asupervised, licensed residential program, the program must have 24-hour-a-day residential staffing, and the staff musthave 24-hour-a-day immediate access to a qualified mental health professional, clinical trainee or qualified mental health practitioner.

D. A crisis stabilization treatment plan must be developed, and services must be delivered according to the plan. A plan must be completed within 24 hours of beginning services and developed by a mental health professional, clinical trainee or ~~a~~mental health practitioner ~~under the clinical supervision of a mental health professional~~. At a minimum, the plan must contain:

1) ~~A list of~~ Information on problems, strengths and resources identified in the assessment;
2) ~~A list of the recipient's strengths and resources~~ identification of crisis assistance that has been helpful to the recipient in the past;
3) Concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement;
4) Specific objectives directed toward the achievement of each one of the goals;
5) Documentation of the participants involved in the service planning. The recipient, if possible, must participate;
6) Planned frequency and type of services initiated;
7) The crisis response action plan if a crisis should occur;and
8) Clear progress notes on the outcome of goals.

E. For a crisis service delivered in a residential setting, the activities of crisis assessment and intervention must be included in the provision of crisis stabilization. Otherwise, a crisis stabilization service must not be provided without providing crisis intervention first.

13.d. Rehabilitative services. (continued)

3. **Community intervention** is the consultation with relatives, guardians, friends, employers, treatment providers, and other significant people, in order to change situations and allow the recipient to function more independently. The consultation must be directed exclusively to the treatment of the recipient.

~~**Telemedicine services. Crisis response service,** except residential crisis stabilization services, that are otherwise covered is direct face to face services may be provided via two way, interactive video if medically appropriate to the condition and needs of the recipient.~~

The services below are not eligible for medical assistance payment as mental health crisis response services:
1. Recipient transportation services.
2. Services provided by a nonenrolled Medicaid provider.
3. Room and board.
4. Services provided to a recipient admitted to an inpatient hospital.
5. Services provided by volunteers.
6. Direct billing of time spent "on call" when not providing services.
7. Provider service time paid as part of case management services.
8. Outreach services, defined on page 54g.

- **Intensive outpatient program dialectical behavior therapy services** are approved by a mental health professional as defined in item 6.d.A, with specialized skill in dialectical behavior therapy, following a comprehensive evaluation which includes a diagnostic assessment, functional assessment and review of prior treatment history. A comprehensive evaluation completed by ~~a mental health practitioner working as~~ a clinical trainee must be reviewed and signed by the mental health professional~~ who is the clinical supervisor~~. Services are provided pursuant to an individual treatmentplan.

A recipient appropriate for dialectical behavior therapy must have mental health needs that cannot be met with other available community-based services or that must be provided concurrently with other community based services and:

1. have a diagnosis of borderline personality disorder; or

13.d. Rehabilitative services. (continued)

2. have multiple mental health diagnoses and is exhibiting behaviors characterized by impulsivity, intentional self-harm behavior and is at significant risk of death, significant morbidity, disability and/or severe dysfunction across multiple domains.

A recipient must:

1. Understand and be cognitively capable of participating in dialectical behavior therapy as an intensive therapy program and be able and willing to follow program policies and rules assuring safety of self and others; and

2. Be at significant risk of one or more of the following if dialectical behavior therapy is not provided:
   a. a mental health crisis
   b. requiring a more restrictive setting (such as hospitalization)
   c. decompensation
   d. engaging in intentional self-harm behavior

Components of dialectical behavior therapy

1. Individual Dialectical Behavior Therapy
Individual dialectical behavior therapy is a combination of individualized rehabilitative and psychotherapeutic interventions to treat suicidal and other dysfunctional coping behaviors and reinforce the use of adaptive skillful behaviors by:
a. identifying, prioritizing and sequencing behavioral targets;
b. treating behavioral targets;
c. generalizing dialectical behavior therapy skills to recipients' natural environment;
d. measuring progress toward dialectical behavior therapy targets;
e. managing crisis and life-threatening behaviors; and
f. assisting recipients to learn and apply effective behaviors in working with other treatment providers.

.13. d. Rehabilitative services. (continued)

Individual dialectical behavior therapy is provided by a mental health professional ~~or a mental health practitioner working as~~ a clinical trainee as defined in item 6.d.A. who is employed by, affiliated with or contracted by a dialectical behavior therapy program certified by the Department.

2. Group dialectical behavior therapy skills training

Group dialectical behavior therapy is a combination of individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group format to reduce suicidal and other dysfunctional coping behaviors and restore function through teaching adaptive skills in the following areas:

d. Cognitive restructuring, anger and crisis-management skills necessary to tolerate distress and regulate emotion;

e. Basic living, behavior management, engagement, leisure and social skills necessary to function in the community;

f. Assertiveness, interpersonal and problem solving skills necessary for interpersonal effectiveness.

Group dialectical behavior therapy skills training is provided by two mental health professionals as defined in item 6.d.A. or a combination of a mental health professional co-facilitating with ~~a mental health practitioner working as~~ a clinical trainee as described in item 6.d.A. ; or a mental health practitioner as defined at pages 54c and c.1 of item 13d, who are employed by, affiliated with or contracted by a dialectical behavior therapy program certified by the Department.

Provider Qualifications, Standards, Training and Supervision

2. Programs are certified by the Department to provide dialectical behavior therapy program components if they meet the following criteria:

a. hold current accreditations as a dialectical behavior therapy program from a nationally recognized certifications and accreditation body or submit to the commissioner's inspection and provide evidence that the dialectical behavior therapy provider will continuously meet ~~the~~those requirements ~~of Minnesota Rule 9505.0372, subpart 10~~; and

.13. d. Rehabilitative services. (continued)

b. enroll as a Minnesota Healthcare Program provider;

c. Collect and report client-level and program outcomes as specified by the department ; -

d. maintain a program manual that outlines the dialectical behavior therapy program′s policies, procedures, and practices. ~~which meet the criteria of Minnesota rule 95905.0372, subpart 10~~

2. Programs consist of persons who are trained in dialectical behavior therapy treatment and meet the following qualifications, training and supervision standards.

Dialectical behavior therapy team leads must:

1.. Be a mental health professional as defined in item 6.d.A. who is employed by, affiliated with or contracted by a dialectical behavior therapy program certified by the Department;
2. Have appropriate competencies and working knowledge of the dialectical behavior therapy principles and practices; and
3. Have knowledge of and ability to apply the principles and practices of dialectical behavior therapy consistently with evidence-based practices.

Dialectical behavior therapy **team members** providing individual dialectical behavior therapy or group skills training must:

.1. Bea mental health professional as defined in item 6.d.A. or be a mental health practitioner as defined on pages 54Cc and c.1 of this item or ~~a mental health practitioner working as~~ a clinical trainee, who is employed by, affiliated with or contracted with a dialectical behavior therapy program certified by the Department;

.13. d. Rehabilitative services. (continued)

6. Have or obtain knowledge of and ability to apply the principles and practices of dialectical behavior therapy consistently with evidence-based practices within the first six months of becoming part of a dialectical behavior therapy program

7. Participate in dialectical behavior therapy consultation team meetings; and

8. For mental health practitioners and clinical trainees, receive ongoing ~~clinical~~ supervision by a mental health professional who has appropriate competencies and working knowledge of the dialectical behavior therapy principles and practices.

13.d. Rehabilitative services. (continued)

~~7. Provider service time paid as part of case management services.~~
~~8. Outreach services, defined on page 54g.~~

- Assertive community treatment (ACT) services are recommended by a mental health professional defined in item 6.d.A. after a diagnostic assessment and a functional assessment. They are provided pursuant to an individual treatment plan. Recipients must be over age 18. Individuals age 16 or 17 may receive ACT services upon approval by the Department.

The following are eligible to provide ACT services:

1. County or other entity certified by the Department.
2. An entity seeking to serve a subpopulation of recipients if the provider demonstrates to the Department that the subpopulation:

   a. requires a specialized program that is not available; and

   b. is of such a low incidence that it is not feasible to develop a program serving a single county or regional group of counties.

3. A facility of the Indian Health Service or a facility owned or operated by a tribe or tribal organization and funded by either Title I of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, or Title I of the Indian Self-Determination and Education Assistance Act, P.L. 106-260, operating as a 638 facility.

Provider Qualifications, Training and Supervision
ACT services are provided by a multidisciplinary staff using a total team approach and assertive outreach for treatment in a recipient's environment. The team includes a clinical supervisor who is a mental health professional as ~~defined on page 54e~~defined in item 6.d.A, and other staff consistent with the Tool for Measurement of Community Assertive Treatment~~Dartmouth Assertive Community Treatment Scale, which establishes national fidelity standards~~. Team members include:

1. A **psychiatric care provider**, who is either a licensed psychiatrist or an advanced practice registered nurse who qualifies as a mental health professional under item 6.d.A;

13.d. Rehabilitative services. (continued)

2. A **nurse**, who is either a registered nurse, or an advanced practice registered nurse;
3. A **specialist in co-occurring disorders**, who has received Department approved training on co-occurring disorders, and is either a licensed alcohol and drug counselor; a licensed professional counselor with a master's degree, which included 120 hours of a specified course of study in addiction studies with 440 hours of post-degree supervised experience in the provision of alcohol and drug counseling as defined in this item; a mental health practitioner, as defined in this item; or a mental health professional as defined in item 6.d.A.
4. A **vocational specialist**, who has at least one year experience in providing employment services or advanced education that involved field training in vocational services to individuals with mental illness, or has completed a Department approved training program; and is either a mental health practitioner as defined in this item, or a mental health professional as defined in item 6.d.A.
5. A **mental health certified peer specialist (level I or II)** as defined in this item.

~~The team members must meet the qualifications, training and supervision standards that apply to adult rehabilitative mental health services.~~

The team must provide the following:

1. ~~The components of adult rehabilitative mental health services.~~
2. ~~Integrated dual diagnosis treatment.~~
3. ~~Medication monitoring and training in medication self-administration.~~
4. ~~Illness management and recovery.~~
5. ~~Case management.~~
6. ~~Psychological support and skills training.~~
7. ~~Consultation with relatives, guardians, friends, employers, treatment providers, and other significant people, in order to change situations and allow the recipient to function more independently. The consultation must be directed exclusively to the treatment of the recipient.~~
8. ~~Crisis services, including development of a crisis plan with the recipient.~~

13.d. Rehabilitative services. (continued)

1. assertive engagement;
2. psychosocial rehabilitative services that develop and enhance a client's psychiatric stability, including basic living and social-skills therapies;
3. treatment of co-occurring mental illness and substance use disorder, including assertive outreach, goal setting, relapse prevention, and related services;
4. crisis assessment and intervention;
5. family psychoeducation and support when provided for the direct benefit of the client;
6. skills therapies directed at housing-related activities and supports, including individual housing-transition skills and individual housing and tenancy-sustaining skills;
7. medication education, assistance, and support;
8. mental health certified peer specialists services;
9. health and wellness self-management services;
10. symptom management; and
11. empirically supported, psychotherapeutic interventions to address mental health symptoms and behaviors.

- **Intensive Residential Treatment Services (IRTS)** are recommended by a mental health professional defined in item 6.d.A. ~~after a diagnostic assessment and a functional assessment. They~~ and are provided pursuant toan individual treatment plan. A diagnostic assessment and functional assessment are required to establishing continuing eligibility and for service delivery planning.

  ~~These services are provided to a recipient~~ age 18 and older ~~meeting the same eligibility requirements for ACT services~~, ~~but the recipientalso requires the level of care and supervision provided in a residential setting.~~ These 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 are directed toward a targeted discharge date with specified recipient outcomes and are consistent with evidence-based practices.

13.d. Rehabilitative services. (continued)

An individual is eligible for Intensive Residential Treatment Services:

(1) is age 18 or older;

(2) is eligible for medical assistance;

(3) is diagnosed with a mental illness;

(4) because of a mental illness, has substantial disability and functional impairment in three or more domains within the client's functional assessment, so that self-sufficiency is markedly reduced;

(5) has one or more of the following: a history of recurring or prolonged inpatient hospitalizations in the past year, significant independent living instability, homelessness, or very frequent use of mental health and related services yielding poor outcomes; and

(6) in the written opinion of a licensed mental health professional, has the need for mental health services that cannot be met with other available community-based services, or is likely to experience a mental health crisis or require a more restrictive setting if intensive rehabilitative mental health services are not provided.

The following are eligible to provide intensive residential treatment ~~residential rehabilitative~~ services:

1. A county-operated or non-countyoperated entity certified by the Department.

~~2. An entity seeking to serve a subpopulation of recipients if the provider demonstrates to the Department that the subpopulation:~~
~~a. requires a specialized program that is not available from county-approved entities; and~~
~~b. is of such a low incidence that it is not feasible to develop a program serving a single county or regional group of counties.~~

3. A facility of the Indian Health Service or a facility owned or operated by a tribe or tribal organization and funded by either TitleI of the Indian Self-Determination and Education Assistance Act, P.L.93-638, as amended, or Title I of the Indian Self-Determination and Education Assistance Act, P.L. 106-260, operating as a 638 facility.

Each provider must have a 24-hour residential care and program services license to provide services for five to sixteen adults withmental illness.

Provider Qualifications, Training and Supervision

Intensive residential treatment services are providedby a multidisciplinary staff for recipients with serious mental illness. The team includes a ~~clinical~~ supervisor who is a mental health professional as defined on page 54e and sufficient staff to comply with the staffing ratio, which

13.d. Rehabilitative services. (continued)

is at least one staff for every nine recipients for each day and evening shift. If more than nine recipients are present at the residence, there must be a minimum of two staff during day and evening shifts, one of whom must be a mental health professional, clinical trainee or a mental health practitioner.

Team members must meet the qualifications, training and supervision standards that apply to adult rehabilitative mental health services, except that mental health rehabilitative workers acting as overnight staff need only meet the qualifications listed in item 2, subitems A through Con page 54c.1. Members of the team provide only those services that are within their scope of practice. A mental health rehabilitation worker under the supervision of a mental health professional can provide skills training and education, medication monitoring, resident supervision and direction, inter-agency coordination, and crisis services.

The team must provide the following:

1. The components of adult rehabilitative mental health services.
2. ~~Integrated dual diagnosis~~Co-occurring substance use disorder treatment.
3. ~~Medication monitoring and training in medication self-administration.~~health services and administration of medication
4. Illness management and recovery.
5. Psychological support and skills training.
6. Consultation with relatives, guardians, friends, employers, treatment providers, and other significant people, in orderto change situations and allow the recipient to function more independently. The consultation must be directed exclusively to the treatment of the recipient.
7. Crisis services.
8. Resident supervision and direction.
9. ~~Inter-agency coordination.~~Referrals for other services in the community.

The services below are not eligible for medical assistance payment as intensive residential treatment services:

1. Recipient transportation services otherwise reimbursed under this Attachment.
2. Services billed by a nonenrolled Medicaid provider.

13.d. Rehabilitative services. (continued)

3. Services provided by volunteers.
4. Direct billing of days spent "on call" when not providing services.
5. Job-specific skills services, such as on-the-job training.
6. Performance of household tasks, chores, or related activities for the recipient.
7. Provider service time eligible for payment as case management services.
8. Outreach activities, as defined for adult rehabilitative mental health services on page 54g.
9. Inpatient hospital services. This includes services provided by an institution for mental disease.

~~**Telemedicine services.** Physicians' services provided to recipients through the intensive residential treatment services benefit, which are otherwise covered as direct face-to-face services, may be provided via two-way, interactive video if medically appropriate to the condition and needs of the recipient.~~

13.d. Rehabilitative services. (continued)

3. **Medication assisted therapy**. This service uses medication as a therapeutic support in conjunction with individual and group therapy. This includes but is not limited to methadone, naltrexone, and buprenorphine.
4. **Treatment coordination**. Treatment coordinators synchronize health services with identified patient needs, to facilitate the aims of the care plan. Activities include treatment follow-up, on-going needs assessments, life skills advocacy, education, service referral, and documentation.
5. **Peer recovery support services**. Recovery peers provide mentoring, education, advocacy and nonclinical recovery support to the recipient.

Up to four hours of individual or group treatment, two hours of treatment coordination, and two hours of peer support services may be covered prior to the comprehensive assessment and treatment plan, based on a positive result of a Screening, Brief Intervention, and Referral to Treatment (SBIRT).

Provider Qualification and Training
The following personnel can provide substance use disorder services:

1) A licensed alcohol and drug counselor is qualified to provide the comprehensive assessment, individual and group therapy, medication assisted therapy, and treatment coordination.

2) A counselor supervisor of licensed alcohol and drug counselors must have three years of work experience as a licensed drug and alcohol counselor and is qualified to provide the comprehensive assessment, individual and group therapy, medication assisted therapy, and treatment coordination.

3) Licensed Social workers, licensed marriage and family therapists, and licensed professional counselors who have a master’s degree, which included 120 hours of a specified course of study in addiction studies with 440 hours of post-degree supervised experience in the provision of alcohol and drug counseling. This provider is qualified to provide the comprehensive assessment, individual and group therapy, medication assisted therapy, and treatment coordination.

4) Personnel providing substance use disorder services at programs licensed by American Indian tribal governments must be credentialed according to the standards set by the individual tribal governing body, and are qualified to provide the comprehensive assessment, individual and group therapy, medication assisted therapy, peer recovery support services, and treatment coordination.

13.d. Rehabilitative services. (continued)

- Peer recovery support services;
- A health assessment;
- Nursing care provided 24 hours per day, including daily medical evaluation;
- Medication administration; and
- A comprehensive assessment.

A **medically monitored program** ~~meets the ASAM level III.7.D level of care criteria by providing~~ provides 24-hour medically supervised evaluation and withdrawal management. This level of care is for individuals whose withdrawal signs and symptoms are sufficiently severe to require ~~medical professionals~~ licensed practitioners but not an inpatient hospital level of care. Services are supervised by a medical director who must be on site seven days a week and available for consultation or onsite recipient monitoring 24 hours per day. A registered nurse must be on site 24 hours a day.

Additionally, a medically monitored program must meet the following staffing requirements:

- The program director, the medical director, or a licensed registered nurse must be present and awake at all times.
- A licensed alcohol and drug counselor is required for every 16 patients served by the program.
- A technician must be awake and on duty at all times for every ten patients served by the program. All staff whose qualifications meet or exceed those for a technician and who are performing the duties of a technician may be counted as a technician for purposes of this requirement. The same individual may not be counted as both a licensed alcohol and drug counselor and a technician.

A medically monitored program must provide the following services as medically appropriate:

- Individual and group therapy;
- Treatment coordination;
- Peer recovery support services;
- A health assessment with the ability for a consultation with a licensed practitioner ~~qualified medical professional~~ if the assessment indicates it is medically necessary;
- Nursing care provided 24 hours per day, including daily medical evaluation;
- Onsite monitoring seven days per week by a qualified medical professional;
- Medication administration and
- A comprehensive assessment.

13.d. Rehabilitative services. (continued)

Up to four hours of individual or group treatment, two hours of treatment coordination, and two hours of peer support services may be covered prior to the comprehensive assessment and treatment plan, based on a positive result of a Screening, Brief Intervention, and Referral to Treatment (SBIRT).

Provider Qualification and Training

The following personnel can provide substance use disorder services:

1) A licensed alcohol and drug counselor is qualified to provide the comprehensive assessment, individual and group therapy, medication assisted therapy, withdrawal management, and treatment coordination.

2) A counselor supervisor of licensed alcohol and drug counselors must have three years of work experience as a licensed drug and alcohol counselor and is qualified to provide the comprehensive assessment, individual and group therapy, medication assisted therapy, withdrawal management, and treatment coordination.

3) Licensed Social workers, licensed marriage and family therapists, and licensed professional counselors who have a master's degree, which included 120 hours of a specified course of study in addiction studies with 440 hours of post-degree supervised experience in the provision of alcohol and drug counseling. This provider is qualified to provide the comprehensive assessment, individual and group therapy, medication assisted therapy, withdrawal management, and treatment coordination.

4) Personnel providing substance use disorder services at programs licensed by American Indian tribal governments must be credentialed according to the standards set by the individual tribal governing body, and are qualified to provide the comprehensive assessment, individual and group therapy, medication assisted therapy, peer recovery support services, withdrawal management, and treatment coordination.

13.d. Rehabilitative services. (continued)

4) Treatment coordinators that meet the following requirements, and working under the clinical supervision of a licensed professional described above, are qualified to provide treatment coordination services:

- skilled in identifying and assessing a wide range of client needs,
- knowledgeable about local community resources and how to use them,
- have successfully completed ~~30~~ 15 hours of ~~classroom instruction on treatment~~ education or training on substance use disorder, co-occurring conditions, and care coordination for an individual with substance use disorder or co-occurring condition,
- have at least ~~2,000~~ 1,000 hours of supervised experience working with individuals with substance use disorder or co-occurring conditions, or receives treatment supervision at least once per week until obtaining 1,000 hours of supervised experience working with individuals with substance use disorder or co-occurring conditions, and
- have a ~~bachelor's degree in one of the behavioral sciences or a related field or be certified as a Level I alcohol and drug counselor by the upper Midwest Indian Council on Addictive Disorders~~ high school diploma or equivalent or is a mental health practitioner.

5) Recovery peers that meet the following requirements, and working under the clinical supervision of a licensed professional described above, are qualified to provide peer recovery support services:

- a minimum of one year in continuous recovery from substance use disorder;
- credentialed by a certification body approved by the Commissioner;
- successfully complete peer specialist certification training, approved by the Department that teaches specific skills relevant to providing peer support to other consumers; and
- complete 20 hours of relevant continuing education every two years in topics such as ethics and boundaries, advocacy, mentoring and education, and recovery and wellness support.

6) Technicians, working under the clinical supervision of a licensed professional in a withdrawal management program, perform basic medical activities such as checking vitals, performing screenings, and managing basic patient care. A technician must:

- Have a current first aid certification from the American Red Cross, or equivalent organization;
- Have a current CPR certification from the American Red Cross, the American Heart Association, or equivalent organization, and
- The knowledge and ability to perform basic medical screening procedures, first aid, and basic activities of daily living and personal hygiene.

13.d. Rehabilitative services. (continued)

8) A person licensed to practice practical or professional nursing in the state of Minnesota may provide services as part of a withdrawal management program.

9) A medical director is either a physician as described in item 5.a., a clinical nurse specialist as described in in item 6.d.H., or a nurse practitioner as described in item 6.d.E.

10) A qualified medical professional is either a physician as described in item 5.a., a clinical nurse specialist as described in in item 6.d.H., or a nurse practitioner as described in item 6.d.E.

Rehabilitative physical therapy, occupational therapy, and speech, language and hearing therapy services.

Coverage is limited to services within the limitations provided under Items 11.a. to 11.c., Physical therapy services, Occupational therapy services, and Speech, language and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist), except:

13.d. Rehabilitative services. (continued)

1) Services that are provided by a rehabilitation agency that take place in a sheltered workshop in a day training and habilitation center or a residential or group home that is an affiliate of the rehabilitation agency are not covered.
2) Social and vocational adjustment services are not covered, but must be provided as an unreimbursed adjunct to the covered services.

Covered **respiratory therapy services** are those prescribed by a physician and provided by a qualified respiratory therapist.

EPSDT rehabilitative services identified in either an Individualized Family Service Plan or an Individualized Education Plan under the Individuals with Disabilities Education Act (IDEA) and provided to children with IFSPs or IEPs during the school day.

Covered services include: ~~IFSP or IEP~~ evaluations or assessments that are medical in nature and used to determine the need for services as part of an ~~result in IFSPs or IEPs that include covered~~ IEP or IFSP ~~services~~, or determine the need for continued coverage~~ed~~ of services under an IEP or IFSP ~~services~~; speech, language and hearing therapy services; mental health services; physical and occupational therapy; and assistive technology devices.

Covered services also include nursing services, such as catheterization, suctioning, tube feedings, medication management, and ventilator care. Nursing services also includes complex or simple medication administration. Medication administration must be related to a child's disability and included in an IFSP or IEP for treatment of the identified disability.

- Simple medication administration is an exception to the requirement in the following paragraph that EPSDT rehabilitative services identified in an IFSP or IEP must be services otherwise covered in this Attachment.

The services must meet all the requirements otherwise applicable if the service had been provided by a qualified, enrolled provider other than a school district, in the following areas: a covered service, medical necessity, documentation, personnel qualifications, and invoicing and prior authorization requirements.

Appropriate nursing services must be provided pursuant to a physician's order. All other services must be provided pursuant to an order of a licensed practitioner of the healing arts.

13.d. Rehabilitative services. (continued)

Appropriate children's therapeutic services and supports (mental health services) must be provided by a provider certified pursuant to Item 4.b., except that school districts are not required to provide children's therapeutic services and supports that they would not otherwise provide.

Covered services must be furnished by the following personnel:

(1) Audiologists meeting the requirements in 42 CFR Part 440.110.

(2) Occupational therapists certified by the National Board for Certification in Occupational Therapy who maintain state licensure as occupational therapists and meet the requirements of 42 CFR 440.110.

(3) Physical therapists meeting the requirements in 42 CFR Part 440.110.

(4) Speech-language pathologists:

(a) meeting the requirements in 42 CFR Part 440.110;

(b) who hold a masters degree in speech-language pathology; and

(c) who are licensed by the state as speech-language pathologists.

(5) Mental health professionals as defined in item 6.d.A.

(6) Mental health practitioners, practicing under the supervision of mental health professionals,

13.D. Rehabilitative services.

(continued) as defined in

item 4.b.

Mental health practitioners cannot provide psychological testing or diagnostic assessments.

(7) Mental health behavioral aides as defined in item 4.b., working under the direction of either mental health professionals who assume full professional responsibility or mental health practitioners under the ~~clinical~~ supervision of mental health professionals who assume full professional responsibility.

(8) Physicians who have a current Minnesota license as a physician.

(9) Registered nurses and licensed practical nurses who have a current Minnesota license as registered nurses or practical nurses.

(10) Clinical trainees as defined in item 6.d.A

13.d. Rehabilitative Services. (continued)

Certified Community Behavioral Health Center Services

Certified Community Behavioral Health Center(CCBHC) services include a comprehensive set of outpatient, community-based behavioral health services and supports that take an integrated, whole-person approach through coordination with physical health and social service providers. All CCBHC services are furnished by qualified individual practitioners affiliated with Minnesota's CCBHCs. The following table of services are provided in accordance with the Rehabilitative Services (§ 13d.) benefit by qualified individual practitioners affiliated with state certified community behavioral health centers. CCBHC services that involve the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service(s) must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

CCBHC Services Included in the Rehabilitative Services Benefit		
Service	**Covered Components**	**Provider Qualifications**
Mental health crisis response services	Crisis response services include crisis assessment, crisis intervention, crisis stabilization and community intervention as listed in the rehabilitative services benefit (item 13.d.)	As listed in the rehabilitative services benefit (item 13.d.)
Mental Health Crisis Response Services for Children	Crisis response services for children include crisis assessment, crisis intervention, and crisis stabilization as listed in the EPSDT benefit (item 4.b.)	As listed under the EPSDT benefit (item 4.b.)
Community Mental Health Center services	Diagnostic assessment, explanation of findings, family, group and individual psychotherapy, including crisis intervention psychotherapy services, multiple family group psychotherapy, psychological testing, medication management, adult day treatment, neuropsychological services, including neuropsychological assessment and neuropsychological testing and 24-hour emergency care as listed in the rehabilitative services benefit (item 13.d.)	Mental health professional defined in item 6.d. A. Mental health practitioner as listed in the rehabilitative services benefit (item 13.d.1.) Clinical Neuropsychologist as listed in the rehabilitative services benefit (item 13.d.)
Adult rehabilitative mental health services (ARMHS)	As listed in the rehabilitative services benefit (item 13.d.)	As listed in the rehabilitative services benefit (item 13.d.1 and 13.d.2.)
Dialectical behavioral therapy	As listed in the rehabilitative services benefit (item 13.d.)	As listed in the rehabilitative services benefit (item 13.d.)
Children's therapeutic services and supports	As listed in the EPSDT services benefit (item 4.b.)	As listed in the EPSDT services benefit (item 4.b.)
Certified family peer specialists	As listed in the EPSDT services benefit (item 4.b.)	As listed in the EPSDT services benefit (item 4.b.)
Substance Use Disorder (SUD) services	Comprehensive assessments, individual and group therapy, SUD treatment coordination, and recovery peer supports (item 13.d.)	As listed in the rehabilitative services benefit (item 13.d.)
Family psychoeducation services	As listed under the EPSDT benefit (item 4.b.). Services provided to the family are in support of the beneficiary.	Family psychoeducation services are provided by a mental health professional, or a mental health practitioner working as a clinical trainee, as defined in Item 6.d.A.
Assertive community treatment	Limited to family psychoeducation services. Assertive community treatment services are under the rehabilitative services benefit (item 13.d.)	As listed in the rehabilitative services benefit (item 13.d.)

13.d. Rehabilitative Services. (continued)

The following table of services currently authorized under the Other Licensed Practitioners Services, (§ 6d.), Physicians' Services (§ 5a.), and Targeted Case Management (Supplement 1) benefits, and provided by qualified individual practitioners affiliated with state certified community behavioral health centers:

CCBHC Services Covered Elsewhere in the State Plan		
Service	**Covered Components**	**Provider Qualifications**
Psychiatric services	Limited to biofeedback training. Psychiatric services are under the physician services benefit (item 5.a)	As listed under the physician services benefit (item 5.a.)
Mental Health Targeted Case Management	As described in Supplement 1 to Attachment 3.1-A/B	As listed in item E.1. of Supplement 1 to Attachment 3.1-A/B
Mental Health Services	Includes the development of individualized treatment plans based on a diagnostic and functional assessment, documents the plan of care and guides treatment interventions, as described in 6.d. A. Other practitioners' services	Provided by a mental health professional as listed in item 6.d.A.

The following table of additional services are provided in accordance with all federal requirements applicable to the 1905(a)(13) benefits, and provided by qualified individual practitioners affiliated with state certified community behavioral health centers:

Other CCBHC Services		
Services	**Covered Components**	**Provider Reuqirements**
Integrated Treatment Plan	The integrated treatment plan is a documented plan of care that, based on the member's goals, guides treatment interventions and documents coordination of medical, psychosocial, emotional, therapeutic, and support needs of their member in a manner consistent with their cultural and linguistic needs. The integrated treatment plan is the result of person and family-centered planning process that includes the member, any family or member-defined natural supports, CCBHC service providers, and care coordination staff.	The integrated treatment plan must be reviewed and signed by a mental health professional as defined in item 6.d.A.
Outpatient withdrawal management	Outpatient withdrawal management is a time-limited service delivered in an office setting, an outpatient behavioral health clinic, or in a person's home by staff providing medically supervised evaluation and detoxification services to achieve safe and comfortable withdrawal from substances and facilitate transition into ongoing treatment and recovery. Services include: assessment, withdrawal management planning, medication prescribing and management, trained observation of withdrawal symptoms and supportive services to encourage the person's recovery.	Outpatient withdrawal management services may be provided by a DEA waivered prescriber to prescribe buprenorphine, a registered nurse under the supervision of a physician, a mental health professional as listed in item 6.d.A., a licensed alcohol and drug counselor listed in item 13.d, or a mental health practitioner under the supervision of a mental health professional as defined in item 6.d.A.

13.d. Rehabilitative Services. (continued)

Other CCBHC Services (cont'd)		
Functional Assessment	The functional assessment is listed in the rehabilitative services benefit (item 13.d.) as a component of adult rehabilitative mental health services (ARMHS) services. A complete functional assessment is an assessment of functional ability identifying and describing functional strengths and deficits, the person's current status within each life area domain, and the linkage between the individual's mental health and the level of functioning. The assessment of functional ability informs the level of care assessment which determines the service intensity needs of the individual.	A mental health professional or practitioner as described in item 6.d.A., a certified peer specialist level II, or mental health rehabilitation worker as described in the rehabilitative services benefit (13.d.)
Certified peer specialist services	Certified peer specialist services are listed in the rehabilitative services benefit (item 13.d.) as a component of adult rehabilitative mental health (ARMHS) services. Certified peer specialists provide non-clinical peer support, promote recipient ownership of the care plan, assist beneficiaries with specific recovery-focused activities, and participate as a member of the mental health team.	Certified Peer Specialist Level I or Level II as listed in the rehabilitative services benefit (item 13.d.3.)

Provider Eligibility

Organizational providers of CCBHC services must be a not for profit or a part of a local government behavioral health authority or operated under the authority of the Indian Health Service, an Indian Tribe, or Tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self Determination Act, or an urban Indian organization pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act.

Providers eligible for reimbursement as a CCBHC must meet certification standards established by the Department in accordance with state law. State certification standards include the following staffing and service delivery requirements:

- **Staffing Criteria:** Staff must have diverse disciplinary backgrounds, have necessary State required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic's population.

- **Availability and Accessibility of Services:** CCBHCs must make services available and accessible to individuals and families of all ages, use a sliding fee scale and may not refuse or limit service based on the person's ability to pay or place of residence.

Additionally, the two activities described below must be performed by all enrolled CCBHCs as a condition of participation. CCBHCs may not bill for these activities, but the cost of performing these activities for Medical Assistance beneficiaries is included in the payment rate described in Attachment 4.19-B.

13.d. Rehabilitative Services. (continued)

- **Care Coordination:** CCBHCs are required to coordinate care across settings and providers for the people served to ensure seamless transitions across the full spectrum of health services. Care coordination includes documenting a plan of care for medical, behavioral health and social services and supports in the integrated treatment plan, assisting with obtaining appointments, confirming appointments are kept, developing a crisis plan, tracking medication, and implementing care coordination agreements with external providers. Care coordination may include psychiatric consultation to primary care practitioners and mental health clinical care consultation.

- **Preliminary Screening and Risk Assessment**

A prospective CCBHC recipient receives a preliminary screening and risk assessment to determine acuity of recipient need. The person is referred to crisis services if immediate need, or scheduled for an evaluation within 1-10 days, based on acuity determined in the assessment.

Designated Collaborating Organizations are entities with a formal agreement with CCBHCs to furnish CCBHC services. Collaborating organizations furnishing services under an agreement with CCBHCs must observe the same service standards and provider requirements as CCBHCs. CCBHCs maintain responsibility for coordinating care and are clinically responsible for services provided by collaborating organizations.

Service Limitations

Services are delivered in accordance with an individual's CCBHC integrated treatment plan.

14. Services for individuals age 65 or older in institutions for mental diseases.

- See items 14.a. to 14.c.

14.a. Services for individuals age 65 or older in institutions for mental diseases - inpatient hospital services.

- Same service limitations apply as those listed in item 1, Inpatient hospital services.

14.b. Services for individuals age 65 or older in institutions for mental diseases - nursing facility services.

- Same service limitations apply to those listed in item 4.a., Nursing facility services.

14.c. Services for individuals age 65 or older in institutions for mental diseases - intermediate care facility services.

- Same service limitations apply as those listed in item 4.a., Nursing facility services.
- Reserved bed services as provided as indicated in Attachment 4.19-C.

15.a. Nursing facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with §1902(a)(31) of the Act, to be in need of such care.

- Same service limitations apply as those listed in item 4.a., Nursing facility services.

15.b. Intermediate care facility services (other than services in an institution for mental diseases) for persons determined, in accordance with §1902(a)(31) of the Act, to be in need of such care including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

- The same service limitations apply as specified in item 15.a.

16. Inpatient psychiatric facilities services for individuals under 22 years of age:

Services are covered for individuals who have reached age 21, but not age 22, only if an individual was receiving such services during the period immediately preceding the individual's 21st birthday. In these cases, services may be continued up to the date an individual no longer requires services or the date the individual reaches age 22, whichever date is earlier.

- For recipients receiving services in a psychiatric hospital or a hospital with an inpatient psychiatric program, ~~T~~the same service limitations apply as specified in item 1, Inpatient hospital services. The facility must be licensed, and surveyed by the state to ensure it meets the requirements to participate in Medicare ~~JCAHO accredited~~.

- Effective January 1, 2017, services may also be provided to recipients residing in a psychiatric residential treatment facility (PRTF). A PRTF is a psychiatric facility licensed, accredited in accordance with 42 C.F.R. §§ 440.160 and 441.151, and enrolled with the Department. The following requirements must be met:
    - The PRTF must satisfy all requirements in 42 C.F.R. Part 483, subpart G, related to restraint and seclusion;
    - The PRTF may only admit recipients whose need for services has been certified as described in 42 C.F.R § 441.153;

- **Provider qualifications.** Services are delivered by a multi-disciplinary team, employed or contracted by the facility that consists of a team leader and other treatment staff. The team is led by either:
    1) A board-eligible or board-certified psychiatrist,
    2) A doctoral-prepared, clinical psychologist and a physician, or
    3) A physician with specialized training and experience in diagnosis and treatment of mental illness, and a psychologist who has a master's degree in clinical psychology.

16. Inpatient psychiatric facilities services for individuals under 22 years of age:

The treatment team must also include at least one of the following:

1) A licensed independent clinical social worker (LICSW),
2) A registered nurse with specialized training, or one year of experience treating people with mental illness;
3) An occupational therapist, as described in item 11.b., with specialized training, or one year of experience treating people with mental illness; or
4) A board-licensed psychologist.

The treatment team must maintain a staffing ratio of at least one staff person to three residents during normal waking hours, and at least one staff person for every ~~four~~ six residents during normal sleeping hours.

- **Covered services.** Covered services include all medically necessary services covered under Medical Assistance and described in the recipient's plan of care. The treatment team must provide the following:

  - Development of the individual plan of care, including review of the plan every 30 days;
  - Daily therapy as described in the plan of care, including:
    - Individual therapy provided at least two times per week;
    - Family therapy provided at least one time per week; and
    - Group therapy as appropriate;
  - Consultation with other professionals including case managers, primary care professionals, community-based mental health providers, school staff, and other members of the child's support structure;
  - Nursing care to patients 24 hours per day, and
  - Discharge planning.

  Services may also be provided under arrangement by licensed professionals who are not part of the treatment team, but have a contractual agreement with the PRTF. Arranged services may be delivered at the facility or in the community, and may be billed by either the facility or the licensed professional.

17. Nurse midwife services.

Payment is limited to services provided within the scope of practice of the certified nurse midwife. In addition to traditional nurse midwife services, services within the scope of practice are:

- annual physical exams;
- prescribing the full range of birth control methods;
- administering Norplant, Depo Provera;
- diagnosing and treating sexually transmitted diseases;
- preconceptual counseling;
- evaluating breast masses and making referrals for follow-up;
- evaluating abdominal pain and making referrals for follow-up;
- evaluating women for hormone replacement therapy; and
- if administering pediatric vaccines as noted in item 5.a., Physicians' services within the scope of their licensure, certified nurse midwives must enroll in the Minnesota Vaccines for Children Program.

18. Hospice care (in accordance with section 1905 (o) of the Act):

A recipient must meet each of the following conditions to receive hospice services under medical assistance:

(1) The recipient must be certified as terminally ill (i.e., the medical prognosis is that the recipient's life expectancy is six months or less, given that the terminal illness runs its normal course) within two calendar days after hospice care is initiated. A recertification statement saying the recipient is terminally ill must be obtained within two calendar days after the recipient's first 90 days of hospice care (within two calendar days after the beginning of the next 90 day period) and before each 60-day period that follows. If the hospice does not obtain written certification within two calendar days after hospice care begins, a verbal certification may be obtained within these two days and a written certification obtained no later than eight days after care begins.

(2) The recipient must live in the recipient's own home, in the community, or in a long-term care facility.

(3) ~~The~~ Recipients over age 21 must sign an election of hospice statement containing the following:
   (a) the name of the hospice;
   (b) an acknowledgment that the recipient understands that the hospice provides palliative, not curative care;
   (c) an acknowledgment that the recipient's right to receive Medicaid payment for certain other Medicaid services (including Medicaid waivers) is being waived; and
   (d) the recipient or legal representative's signature.

(4) Recipients under age 21 must sign an election of hospice statement containing the following:
   (a) the name of the hospice;
   (b) an acknowledgment that the recipient understands that the hospice provides palliative, not curative care; and
   (c) the recipient or legal representative's signature.

(5) The recipient must receive hospice care until the recipient is no longer certified as terminally ill or until the recipient or representative revokes the election of hospice.

18. Hospice care (in accordance with section 1905(o) of the Act: (continued.)

The core services listed below must be provided directly by hospice employees. A hospice may use contracted staff, such as physicians, dentists, optometrists or chiropractors to supplement hospice employees during periods of peak patient loads or other extraordinary circumstances. The hospice remains responsible for the quality of services provided by contracted staff.

(1) Nursing services provided by or under the supervision of a registered nurse.

(2) Medical social services provided by a social worker under the direction of a physician.

(3) Counseling services provided to the terminally ill recipient and the family members or other persons caring for the recipient at the recipient's home. Counseling, including dietary counseling, may be provided to train the recipient's family or other caregiver to provide care and to help the recipient and those caring for the recipient adjust to the recipient's approaching death.

The following additional services must also be made available by the hospice:

(1) Inpatient care including procedures necessary for pain control or acute or chronic symptom management. Inpatient care is provided in a Medicare or medical assistance certified hospital, a nursing facility or an inpatient hospice unit.

(2) Inpatient care for up to five consecutive days at a time to provide respite care for the recipient's family or other persons caring for the recipient at home. Inpatient care is provided in a Medicare or medical assistance certified hospital, a nursing facility, an inpatient hospice unit, or a Medical Assistance certified intermediate care facility.

18. Hospice care (in accordance with section 1905(o) of the Act: (continued.)

(3) Medical equipment and supplies, including drugs. Only drugs or compounded prescriptions approved by the commissioner for inclusion in the Department's Drug Formulary are covered. The drugs must be used primarily to relieve pain and control symptoms for the recipient's terminal illness. Medical appliances and durable medical equipment are included, as well as other self help and personal comfort items related to the palliation or management of the recipient's terminal illness. Medical appliances must be provided by the hospice for use in the recipient's home while the recipient is receiving hospice care. Medical supplies include those specified in the written plan of care.

(4) Home health aide services and homemaker services. Home health aides may provide personal care services. Home health aides and homemakers may perform household services to maintain a safe and sanitary environment in areas of the home used by the recipient. Examples of household services are changing the recipient's bed linens, or light cleaning and laundering essential to the comfort and cleanliness of the recipient. Home health aide services must be provided under the supervision of a registered nurse.

(5) Physical therapy, occupational therapy, and speech/language pathology services provided to maintain activities of daily living and basic functional skills.

(6) Services of a physician, dentist, optometrist, or chiropractor.

(7) Any other items or services specified in the plan of care for which payment may be made.

There are four levels of care into which each day of hospice care is classified.

(1) Routine home care day. This is a day in which the recipient is at home and is not receiving continuous care during a crisis.

18. Hospice care (in accordance with section 1905(o) of the Act: (continued.)

(2) Continuous home care day. This is a day in which the recipient receives predominately nursing services, and may also receive home health aide or homemaker services on a continuous basis during a period of crisis. The hospice must provide at least eight hours of care and bills using the hourly rate for the actual hours of service provided up to 24.

(3) Inpatient care day. This is a day in which the recipient received inpatient care for respite for the caregiver at home. The hospice may bill for up to five consecutive days beginning with the day of admission but excluding the day of discharge. Any respite care days beyond the five consecutive covered days must be billed as routine home care days.

(4) General inpatient day. This is a day in which the recipient receives general inpatient care in a hospital, nursing facility, or inpatient hospice unit for control of pain or management of acute or chronic symptoms that cannot be managed in the home. The hospice may bill for the date of admission, but not the date of discharge unless the recipient is discharged deceased.

Medical assistance will pay a hospice for each day a recipient is under the hospice's care. The limits and cap amounts are the same as used in the Medicare program except that the inpatient day limit on both inpatient respite care days and general inpatient care days does not apply to recipients afflicted with acquired immunodeficiency syndrome (AIDS).

No payment is made for bereavement counseling.

19. Case management services:

Provided with limitations identified in Supplements 1 through ~~1e~~ 1d to this Attachment.

Special TB-related services under Section 1902(z)(2)(F) of the Act.

The direct observation of the intake of prescribed drugs by outpatient recipients as described in item 6.d.B.

20. Extended services to pregnant women:

- See items 20.a. ~~through~~ and 20.b.

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends:

- The following are extended services for pregnant women ~~which~~ that vary in amount, duration, and scope from other services under this State Plan.

- For the purposes of item 20.a., ``physician'' includes a doctor of osteopathy pursuant to 42 CFR §440.50(a).

PRENATAL RISK ASSESSMENT: All pregnant women receiving prenatal care services funded by the State of Minnesota will be screened for risk of a poor birth outcome. A copy of the risk assessment will be kept in the recipient's medical record. ~~Factors in the assessment will include:~~

~~(1) lifestyle risk, including use of alcohol and illicit or non-prescription drugs, smoking, diet, and activity;~~
~~(2) medical risk;~~
~~(3) genetic risk;~~
~~(4) pre-term birth risk;~~
~~(5) psycho-social risk, including lack of emotional supports, stress, and lack of parenting skills.~~

~~**Risk assessment** activities include:~~

~~(1) To be eligible for MA reimbursement for the delivery of the enhanced perinatal services, a physician, certified nurse midwife, or nurse practitioner shall complete a risk assessment at the recipient's first prenatal visit (and, optionally, again at approximately 24-28 weeks gestation) on the form supplied by the Department of Human Services.~~

~~(2) Physicians, certified nurse midwives, and nurse practitioners must submit the completed risk assessment form to the Department of Human Services.~~

~~(3) The primary provider (physician, certified nurse midwife, or nurse practitioner) will receive a payment for each risk assessment form submitted to the Department (2 payments per pregnancy; limited to 4 payments per year; i.e. more than one pregnancy in a year).~~

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

~~Eligible Providers: Completion of the risk assessment and submission to Department must be performed by the enrolled primary physician, certified nurse midwife, or nurse practitioner.~~

AT RISK ANTEPARTUM MANAGEMENT: If a woman is found to be at risk of a poor birth outcome based on the prenatal risk assessment, the primary physician or certified nurse midwife is eligible for a one-time ~~MA reimbursement~~ medical assistance payment for additional time management based on the woman's risk status.

CARE COORDINATION: The care coordinator for the at risk pregnant recipient must remain consistent and the relationship between the care coordinator and the recipient must be ongoing, with regular interaction, and based on trust if the process is to be effective. Care coordination services are based upon an individualized plan of care for each at risk pregnant woman after assessing the recipient's needs and risks. The care coordinator must make appropriate referrals to resources that will support a healthy pregnancy and improve birth outcomes, monitor recipient progress, synchronize services, advocate for the recipient to assure access to necessary services and maximize use of the most cost effective and appropriate services.

Care coordination services include:

(1) Definition of a pregnant recipient as "at risk" and requiring special needs based on the initial assessment by the primary physician, nurse midwife, or nurse practitioner ~~utilizing the Department's risk assessment form~~.

(2) Development of an individual plan of care that addresses the recipient's specific needs and risks related to the pregnancy.

(3) Involvement of the recipient, family, and recipient support network in the assessment and plan of care.

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

(4) Provision of enhanced perinatal services by the primary provider him/herself or coordination of referrals to appropriate community resources and health care providers eligible for addressing and meeting the recipient's needs related to the pregnancy.

(5) Advocacy for the recipient in working with the various health care providers.

(6) Directly monitoring on an ongoing basis, or ensuring that monitoring is done to determine whether the recipient is, in fact, receiving enhanced perinatal services in a timely and economical manner and that the service is of expected and adequate quality.

Eligible Providers: Care coordination services must be performed by the primary care physician, physician assistant, certified nurse-midwife, clinical nurse specialist, licensed registered nurse, or nurse practitioner. If performed by a registered nurse, the care plan and critical educational needs identified in the plan must be reviewed and approved by the recipient's primary provider. ~~and a~~ A copy of the care coordination plan must be included in the recipient's medical record.

PRENATAL HEALTH EDUCATION I: Health education for the at risk pregnant woman is a core intervention that is preventive, non-invasive and resource-efficient, and enhances compliance with the recipient's individualized plan of care. Educational services will be based upon the ~~client's~~ recipient's identified risks/needs as determined by the ~~Department of Human Services's~~ prenatal risk assessment ~~form~~, as well as consultation and agreement between the care coordinator and recipient. Designated "at risk" ~~clients~~ recipients require innovative and individualized approaches to prenatal care to effectively meet their educational needs. ~~The Department's~~ Educational interventions will target risk factors, medical conditions and health behaviors that can be alleviated or improved through education. Educational services will begin with the initial assessment visit and continue throughout the perinatal period. Services can be provided on a one-to-one basis, in small group settings, or in classes individualized to the ~~client's~~

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

recipient's own needs and interests. The prenatal health education sessions promote behavior changes in the recipient's daily life that will support a healthy pregnancy and result in an improved perinatal outcome.

Prenatal health education will provide information on:

(1) Description and importance of continued prenatal care
(2) Normal changes due to pregnancy (specific to trimester):
  (a) Maternal anatomy and physiology
  (b) Fetal development
  (c) Emotional/psychosexual issues
(3) Comfort measures
(4) Self-care during pregnancy
(5) Pregnancy danger/warning signs/preterm labor and delivery
  (a) Symptoms of preterm labor
  (b) Self-detection of preterm labor
  (c) Treatment
  (d) Preventive measures
(6) Specific medical conditions
  (a) Diagnosis and significance during pregnancy
  (b) Treatment: medications, activity level, options, and rationale
  (c) Appropriate referrals
(7) Birth process
  (a) Anatomy and physiology of labor and delivery
  (b) Coping skills
  (c) Medical management
  (d) Hospital procedures
  (e) Danger signs
  (f) Communication with health providers

~~**Prenatal Health Education I** must include information to prepare the client for the birth process when the recipient is near the end of the second trimester or early third trimester.~~

~~(1) Anatomy and physiology of labor and delivery~~
~~(2) Coping skills~~
~~(3) Medical management~~
~~(4) Hospital procedures~~
~~(5) Danger signs~~
~~(6) Communication with health providers~~

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

~~A pregnant woman may contribute toward preventing preterm labor and delivery. An at risk woman must be instructed in order to provide optimal preventive care:~~

~~(1) Symptoms of preterm labor~~
~~(2) Self-detection of preterm labor~~
~~(3) Treatment~~
~~(4) Preventive measures~~

Eligible Providers: Prenatal Health Education I services must be performed by ~~a~~ the primary care physician, physician assistant, certified nurse midwife, clinical nurse specialist, licensed registered nurse, nurse practitioner, or a health educator with either a baccalaureate level degree in health education or higher and/or ~~SOPHE (Society for Public Health Education)~~ ICEA (International Childbirth Education Association), Lamaze or NCHEC (National Commission for Health Education Credentialing) certification.

PRENATAL HEALTH EDUCATION II

~~Description:~~ Lifestyle and parenting support educational services supplement the Prenatal Health Education I services, and are necessary for recipients who require more time and specialized education to evoke change in risk behaviors and lifestyles as determined by the ~~Department of Human Services's~~ prenatal risk assessment ~~tool~~. Behavior and lifestyle changes resulting from this early and consistent education may also have long term impacts on improving the health of the mother, baby, and subsequent pregnancies.

Providers will address the individual needs of the at risk pregnant woman ~~which~~ that may include:

(1) Education/assistance to stop smoking, alcohol consumption or use of street drugs
   (a) ~~Decrease smoking alternative~~
   ~~(b)~~ Effects of ~~smoking~~ substance use on mother and fetal development
   (b) Referral to support program ~~to quit~~ if needed

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

~~(2) Education/assistance to stop alcohol consumption~~
~~(a) Emphasize importance of no alcohol during pregnancy~~

~~(b) Effect of alcohol on fetal development~~
~~(c) Referral to support program if needed~~

~~(3) Education/assistance to stop use of street drugs~~
~~(a) Emphasize no safe limit~~
~~(b) Effects of drugs on fetal development~~
~~(c) Referral to support program if needed~~

(2) Education on safe use of OTC/prescription drugs
(a) Consult with primary provider

(3) Environmental/occupational hazards
(a) Identify potential exposure to hazard in ~~client's~~ recipient's own environment
(b) Effects on fetal growth and development
(c) Efforts to minimize exposure
(d) Referrals for follow-up if needed

(4) Stress management
(a) Relaxation techniques
(b) Job/unemployment/school problems
(c) Support services
(d) Communication with health care providers
(e) Coping skills

(5) Communication skills and resources
(a) Family support systems
(b) Health care providers

(6) Building of self-esteem

(7) Prenatal parenting; bonding
(a) Identify and affirm prenatal parenting behaviors

(8) Parenting skills to meet the physical, emotional, and intellectual needs of the infant
(a) Infant needs/cares
(b) Nurturing
(c) Infant feeding preparation
(d) Referral to community resources, if needed

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

(9) Planning for continuous, comprehensive pediatric care following delivery.

Eligible Providers: Prenatal Health Education II ~~services~~ for lifestyle and parenting support must be performed by ~~a~~ the primary care physician, physician assistant, certified nurse midwife, clinical nurse specialist, licensed registered nurse, nurse practitioner, health educator with either a baccalaureate level degree in education or higher and/or ~~SOPHE (Society for Public Health Education)~~ ICEA, Lamaze, NCHEC or IBCLC (International Board Certified Lactation Consultants) certification, or a baccalaureate or master's prepared social worker.

PRENATAL NUTRITION EDUCATION:

~~Description:~~ A nutritional assessment with follow-up reassessment and education for the at risk pregnancy must identify nutritional risks and problems the pregnant woman may already have or be in danger of developing as determined by the prenatal risk assessment ~~form~~. An individualized nutrition care plan will be developed for each pregnant woman based on the assessment of her nutritional status with necessary referrals to food assistance programs as appropriate. The nutrition care plan will be incorporated into the overall individualized plan of care for each woman, and will address the prevention/resolution of identified risks and problems. Nutrition interventions will include individual as well as group nutrition education and follow-up, and will provide information that will assist the pregnant woman in making informed nutritional choices and accepting responsibility to change nutritional behaviors to support a healthy pregnancy and result in an improved perinatal outcome.

The nutritional assessment and education component will include:

(1) An initial assessment of "nutritional risk" based upon height, current and pre-pregnancy weight status, laboratory data, clinical data, and self-reported dietary information ~~utilizing the Department's risk assessment tool~~.

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

(2) Ongoing assessment of the pregnant woman's nutritional status (at least once every trimester) as evidenced by dietary information, adequacy of weight gain in pregnancy, other measures to assess uterine/fetal growth, laboratory data, and clinical data.

(3) Development of an individualized nutrition care plan (to be included in recipient's medical record) that addresses the recipient's own nutritional deficits, prioritization of nutritional needs, proposed interventions and time frame with expected outcomes.

(4) Referral to food assistance programs, if indicated (WIC, food stamps, U.S. Department of Agriculture's Mothers and Children Program).

(5) Nutritional interventions; either individual or group education:
(a) Nutritional requirements of pregnancy are linked to fetal growth and development
(b) Recommended Dietary Allowance for normal pregnancy
(c) Appropriate weight gain
(d) Importance of vitamin/iron supplements and recommendations for taking them
(e) Infant nutritional needs and feeding practices, including breast-feeding

(6) Incorporation of pre/postnatal exercise/physical activity program

Eligible Providers: A ~~nutritional assessment and~~ Prenatal nutrition education must be performed by the primary care physician, physician assistant, certified nurse midwife, clinical nurse specialist, licensed registered nurse with specialized training, nurse practitioner, or a qualified dietitian or nutritionist.

POST PARTUM FOLLOW-UP HOME VISIT:

~~Description:~~ There are many possible sources of stress when the mother takes the new baby home, including: feelings of inadequacy in caring for the child; changes in interpersonal relationships; and new burdens of parental responsibility. This visit gives special

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

emphasis for at risk mothers and infants by following up on pre-identified "risk" behaviors and/or medical conditions. Reinforcement and support must be provided when positive behavior changes related to the pregnancy have been required and incorporated into the recipient's lifestyle. Anticipatory guidance about infant care and development will encourage and promote healthier parenting. It is also imperative for the parent(s) to be able to detect signs and symptoms of distress to the infant that require prompt or emergency treatment. The home visit is necessary to anticipate further needs of the mother or infant that may require additional home visits or referral to appropriate health and social service providers. The post partum follow-up home visit will be in addition to and separate from the six week post partum visit with the recipient's primary provider and will be made within the first two weeks after the mother's discharge from the hospital. Individualized information and consistent reinforcement of previously provided services (based on the care plan) will be offered to the recipient at this time.

The provider will address the following:

(1) Assessment of mother's health
  (a) Follow-up "risk" behaviors, and medical conditions
  (b) Support of positive changes made to date

(2) Physical/emotional changes postpartum
  (a) Anticipatory guidance regarding relationship with partner
  (b) Sexual responses
  (c) Potential stress with family
  (d) Nutritional needs
  (e) Physical activity/exercise

(3) Contraception

(4) Parenting skills/support
  (a) Adapting to parenthood
  (b) Parent/child relationship
  (c) Child care arrangements and support

(5) Grief support if unexpected outcome

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

(6) Parenting sick/preterm infant, if indicated
   (a) Follow-up on "risk" factors and conditions

(7) Assessment of infant's health
   (a) Infant weight/growth
   (b) Infant development and abilities

(8) Infant care
   (a) Feeding and infant nutritional needs
   (b) Recognition of illness in the newborn
   (c) Accident prevention
   (d) Immunizations and pediatric care

(9) Identification of community health resources for mother and infant.

(10) Referral to appropriate community health resources for mother and infant.

Eligible Providers: The follow-up home visit must be performed by the recipient's primary care physician, physician assistant, certified nurse midwife, clinical nurse specialist, licensed registered nurse, or nurse practitioner who is able to provide and anticipate needs for guidance. The provider must be able to provide the necessary follow-up and referrals to appropriate medical assistance eligible providers and social service agencies.

Eligible providers: Doula services must be recommended by a licensed practitioner acting within the scope of their practice under state law. They are authorized under the preventive services benefit (42 CFR 440.130(c)). ~~provided under the supervision of a physician, nurse practitioner, or nurse-midwife by a~~ Doulas must be certified by one of the following organizations:

- International Childbirth Education Association;
- Doulas of North America (DONA);
- Association of Labor Assistants and Childbirth Educators (ALACE);
- Birthworks;
- Childbirth and Postpartum Professional Association (CAPPA);
- Childbirth International;
- International Center for Traditional Childbearing; ~~or~~
- Commonsense Childbirth Inc.;
- Modern Doula Education (MDE); or
- Organization designated by the Commissioner of Health

20.b. Services for any other Medical Condition that May Complicate Pregnancy.

- Services are subject to the same limitations already identified for Inpatient hospital, Physician, and Nurse-midwife, etc.

21. Ambulatory prenatal care.

- Not provided.

22. Respiratory care services in accordance with section 1902(e)(9)(A) through (C) of the Act.

- Not provided.

23. Certified pediatric or family nurse practitioner services.

Coverage is limited to:

(1) Services performed by a pediatric nurse practitioner or family nurse practitioner certified by the American Nurses Credentialing Center or the National Certification Board of Pediatric Nurse Practitioners and Nurses, and provided within the scope of practice of the nurse practitioner's license as a registered nurse; and

(2) The types of services covered by medical assistance as ~~physicians'~~ nurse practitioner services under item ~~5.a.~~ 6.d.E that are within the scope of the nurse practitioner's license as a registered nurse.

24. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary.

- See items 24.a. through 24.e.

24.a. Transportation and other services to assure access to covered services:

~~• Medical transportation must be to or from the site of a covered service to a recipient to be eligible for payment. Medicaid also covers transportation of a full-benefit dual eligible to obtain drugs covered under the Medicare Part D benefit.~~

~~• Transportation of a recipient between providers is a covered service with the following limitations:~~

~~1) Transportation between two long term care facilities must be medically necessary because the health services required by the recipient's plan of care are not available at the long term care facility where the client resides. There are two exceptions:~~

~~a) it is an emergency; or~~

~~b) due to the severe winter and spring of 1997, it is necessary to return a recipient to his or her original long term care facility or to a long term care facility closer to the original facility. This subitem expires February 1, 1998.~~

~~2) Transportation between two hospitals must be to obtain a medically necessary service that is not available at the hospital where the recipient was when the medical necessity was diagnosed.~~

~~• Payment for transportation of a deceased person is limited to the following circumstances:~~

~~1) If a recipient is pronounced dead after medical transportation is called but before it arrives, service to the point of pick-up is eligible for payment.~~

~~2) If medical transportation is provided to a recipient who is pronounced dead on arrival, the medical transportation is eligible for payment.~~

24.a. Transportation and other services to assure access to covered services: (continued)

~~3) If a recipient is pronounced dead before medical transportation is called, medical transportation is not eligible for payment.~~

~~• To be eligible for the medical assistance payment rate as a life support transportation, the life support transportation must comply with the following:~~

~~1) The provider must be licensed under Minnesota Statutes, §§144.802 and 144.804.~~

~~2) The recipient's transportation must be in response a 911 emergency call, police or fire department, or an emergency call received by the provider.~~

~~3) The medical necessity of the service must be documented by the state report required under Minnesota Statutes, §144.807.~~

~~4) Life support transportation that responds to a medical emergency is eligible for payment for no load transportation only if the life support transportation provided medically necessary treatment to the recipient at the pick up point of the recipient. The payment is limited to charges for transportation to the point of pick up and for ancillary services.~~

~~• Special transportation is a covered service if the recipient has a physical or mental impairment that would prohibit the recipient from safely accessing and using a bus, taxi, other commercial transportation, or private automobile.~~

~~Such a recipient must not require life support transportation.~~

24.a. Transportation and other services to assure access to covered services: (continued)

~~Special transportation includes driver-assisted service. Driver-assisted service includes:~~

~~1) passenger pickup at and return to the recipient's residence or place of business;~~

~~2) assistance with admittance of the recipient to the medical facility; and~~

~~3) assistance in recipient securement or in securing of wheelchairs or stretchers in the vehicle.~~

~~Payment eligibility of special transportation is subject to the following limitations:~~

~~1) The special transportation and special transportation to reach a health service outside the recipient's local trade area is provided to a recipient who has been determined eligible for special transportation because of physical or mental impairment.~~

~~2) The cost of special transportation of a recipient who receives day services outside the intermediate care facility for persons with mental retardation is not eligible for reimbursement on a separate claim for payment if transportation expenses are included in the per diem payment to the ICF/MR.~~

~~• Transportation by air ambulance shall be eligible for medical assistance payment if the recipient has a life threatening condition that does not permit the recipient to use another form of transportation.~~

~~• The following costs related to transportation are not eligible for payment as medical transportation:~~

~~1) transportation of a recipient to a hospital or other site of health services for detention that is ordered by a court or law enforcement agency except when life support transportation is a medical necessity;~~

24.a. Transportation and other services to assure access to covered services: (continued)

~~2) transportation of a recipient to a facility for alcohol detoxification that is not a medical necessity;~~

~~3) no-load transportation except as allowed for life support transportation;~~

~~4) additional charges for luggage, stair carry of the recipient, and other airport, bus, or railroad transportation services;~~

~~5) airport surcharge;~~

~~6) federal or state excise or sales taxes on air ambulance services;~~

~~7) transportation of a recipient to a non-covered service (e.g., grocery store, health club, place of worship). This does not include transportation of a full-benefit dual eligible to obtain drugs covered under the Medicare Part D benefit;~~

~~8) extra attendant charges for a personal care attendant accompanying a recipient; and~~

~~9) separate base rates for the continuation of a special transportation trip beyond the original destination.~~

~~• Local agencies and the transportation coordinator approve payment from administrative funds for meals, lodging, or interpreters for the hearing impaired when such services are necessary to obtain necessary covered MA services.~~

24.a. Transportation and other services to assure access to covered services.

A. Emergency Transportation Services

Emergency transportation is transportation for the diagnosis and treatment of a condition, including labor and delivery, that if not immediately diagnosed and treated, could cause a person serious physical or mental disability, continuation of severe pain, or death. Emergency transportation usually involves transport to a hospital and does not include those transports that are scheduled in advance.

Covered services include:

1. **Ground Ambulance.** The following ambulance services are covered when provided in the context of an emergency response as described above.

   a. Advanced Life Support, Level 1 (ALS1)

   Transportation by ground ambulance vehicle, medically necessary supplies and services and an ALS assessment by ALS personnel or the provision of at least one ALS intervention as described below in item b.

   b. Advanced Life Support, Level 2 (ALS2)

   Transportation by ground ambulance vehicle and medically necessary supplies and services, plus:

   1. three or more different administrations of medications by intravenous push/bolus or by continuous infusion excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or

   2. the provision of at least one of the following ALS procedures: manual defibrillation/cardioversion; endotracheal intubation; central venous line; cardiac pacing; chest decompression; surgical airway; or introsseous line.

24.a. Transportation and other services to assure access to covered services. (continued)

c. Basic Life Support (BLS), Emergency

Transportation by ground ambulance vehicle and medically necessary supplies and services, plus the provision of BLS ambulance services.

d. Specialty Care Transport (SCT)

Specialty care transport means interfacility transportation of a critically injured or ill recipient by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the EMT or paramedic.

2. Air Ambulance. Emergency transportation by air ambulance is covered if the recipient has a life threatening condition that does not permit the recipient to use another form of transportation.

Covered air ambulance services include:
a. Conventional air services, fixed wing.

b. Conventional air services, rotary wing.

B. School-Based Services

- Station-to-station non-emergency medical transportation is a covered service for a child receiving EPSDT rehabilitative or personal care services identified on an Individual Family Service Plan (IFSP) or Individualized Education Program (IEP) under the Individuals with Disabilities Education Act (IDEA) who has a physical or mental impairment that would prohibit the child from safely accessing and using common carrier transportation such as a bus, taxi, other commercial transportation, or private automobile to receive the covered IEP service. This service is available only when the child receives another covered IEP service on the same day.

  The IEP/IFSP must document the child's need for transportation, including a special adaptation to the vehicle such as a wheelchair lift, special harness, safety vest or special car seat or the need for a one-on-one aide on the vehicle.

24.a. Transportation and other services to assure access to covered services. (continued)

C. Coverage Limitations:

- Emergency ambulance transportation must be to or from the site of a covered service to a recipient to covered.

- Emergency ambulance transportation of a recipient between providers is a covered service except that emergency transportation between two hospitals or two long term care facilities must be to obtain a medically necessary service that is not available at the hospital or long term care facility where the recipient was when the medical necessity was diagnosed.

- Coverage for emergency transportation of a deceased person is limited to the following circumstances:

  1) If a recipient is pronounced dead after emergency transportation is called but before it arrives, service to the point of pick-up is covered.

  2) If emergency transportation is provided to a recipient who is pronounced dead on arrival, the medical transportation is covered.

- To be eligible for medical assistance coverage as emergency ambulance transportation, the ambulance transportation must comply with the following:

  1) The provider must be licensed under Minnesota Statutes, 144E.10 and 144E.16.

  2) The recipient's transportation must be in response to a 911 emergency call, police or fire department, or an emergency call received by the provider.

  3) The medical necessity of the service must be documented.

State/Territory: Minnesota

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

CATEGORICALLY NEEDY GROUP(S)

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: ___X____

I. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

_X__Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

_X__A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

_X__A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unlessit displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 SecurityBoulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

24.a. Transportation and other services to assure access to covered services. (continued)

4) No load emergency ambulance transportation is not covered with the following exceptions:

a. Service to the point of pick-up of a deceased person who is pronounced dead after emergency medical transportation is called but before it arrives.

b. Response to a medical emergency if the ambulance transportation provided medically necessary treatment to the recipient at the pick-up point of the recipient.

c. The coverage is limited to charges for transportation to the point of pick-up and for ancillary services.

24.b. Services of nurses in religious nonmedical health care institutions.

- Not provided.

24.c. Care and services provided in religious nonmedical health care institutions.

- Provided with no limitations.

24.d. Nursing facility services for patients under 21 years of age:

- Same service limitations apply as those listed in item 4.a., Nursing facility services.

24.e. Emergency Hospital Services:

- Emergency services means those medical services required for the immediate diagnosis and treatment of medical conditions that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death or are necessary to alleviate severe pain. ~~Emergency hospital services includes telemedicine consultation services as described in item 5.a., Physicians' services (but only via two-way interactive video).~~

- An outpatient hospital service that is not an emergency but is provided in an area that is designated, equipped, and staffed for emergency services is not eligible for payment as an emergency outpatient hospital service.

- An outpatient hospital service that is not an emergency and which is provided in an area of an outpatient hospital which is advertised, represented, or held out to the public as providing acute, episodic care similar to services provided by a physician-directed clinic is not eligible for payment as an emergency outpatient hospital service.

- Medical records must document that an emergency existed at the time the service was rendered.

25. Home and community care for functionally disabled elderly individuals, as defined, described, and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

- Not provided.

26. Personal care services.

~~Personal care services are provided by personal care provider organizations or by use of the PCA Choice option.~~

~~**A. Personal care provider organizations**~~

~~Personal care services provider qualifications:~~

- ~~Personal care assistants must be employees of or under contract with a personal care provider organization or a fiscal intermediary (PCA Choice)~~

- ~~If a recipient's diagnosis or condition changes, requiring a level of care beyond that which can be provided by a personal care provider, non-Medicare certified personal care providers must refer and document the referral of dual eligibles to Medicare providers (when Medicare is the appropriate payer).~~

- ~~Personal care assistant means a person who:~~

  a) ~~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;~~

  b) ~~is able to effectively communicate with the recipient and the personal care provider organization;~~

  c) ~~is able to and provides covered personal care assistant services according to the~~

26. Personal care services. (continued)

~~recipient's plan of care, responds appropriately to the recipient's needs, and reports changes in the recipient's conditions to the physician or the supervising qualified professional if supervision is requested by the recipient. For the purposes of this item, "qualified professional" means a registered nurse, a mental health professional defined in item 6.d.A. of this attachment, or licensed social worker;~~

~~d) is not a consumer of personal care assistant services;~~

~~e) is subject to criminal background checks and procedures specified in the state human services licensing act; and~~

~~f) maintains daily written records for each recipient detailing the services provided and the amount of time spent providing the services.~~

~~Personal care provider organization means an entity enrolled to provide personal care services under medical assistance that complies with the following:~~

~~a) owners who have a five percent interest or more, and managerial officials are subject to a background study. This applies to currently enrolled personal care provider organizations and those entities seeking to enroll as a personal care provider organization. Effective November 10, 1997, an organization is barred from enrollment if an owner or managerial official of the organization has been convicted of a crime~~

26. Personal care services. (continued)

~~specified in the state human services licensing act, or a comparable crime in another jurisdiction, unless the owner or managerial official meets the reconsideration criteria specified in the state human services licensing act;~~

~~b) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and provide proof thereof. The insurer must notify the Department of the cancellation or lapse of policy;~~

~~c) the organization must maintain the required statutory documentation of personal care assistant services in a recipient file, as well as evidence of compliance with personal care assistant training requirements and all notices to recipients regarding personal care assistant service use at a rate likely to exhaust authorized hours prior to the end of the authorization period;~~

~~d) the organization must communicate with the recipient or responsible party about the schedule for use of authorized hours; and~~

~~e) the organization must notify the recipient and county public health nurse in advance, on a Department form, if the monthly number of authorized hours is likely to exhaust the authorized hours prior to the end of the authorization period.~~

~~f) the organization shall comply with all laws and rules governing the provision of personal care assistant services.~~

26. Personal care services. (continued)

~~B. PCA Choice option~~

~~PCA Choice is a consumer directed personal care service choice. The PCA Choice option allows the recipient to recruit, hire, terminate, train and supervise person care assistants.~~

~~"Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community, is at least 18 years old, actively participates in planning and directing of person care services and is not the personal care assistant.~~

~~"Qualified professional" means a registered nurse, mental health professional or licensed social worker providing supervision of personal care services and staff.~~

~~The recipient or responsible party:~~

~~a) uses a PCA Choice provider, not a personal care provider organization. A PCA Choice provider assists the recipient to account for covered personal care assistant services. A PCA Choice provider is considered a joint employer of the qualified professional described in item A and the personal care assistant, and may not be related to the recipient, qualified professional, or personal care assistant. A PCA Choice provider or owner of the entity providing PCA Choice services must pass a criminal background check according to the state human services licensing act;~~

~~b) if a qualified professional is requested, uses a qualified professional for help in developing and revising a service plan to meet the recipient's needs, as assessed by the public health nurse;~~

~~c) supervises the personal care assistant if the recipient or responsible party does not want a qualified professional to supervise the personal care assistant;~~

~~d) if the recipient or responsible party wants a qualified professional to supervise the personal care assistant, verifies and documents the credentials of the qualified professional, and then recruits, hires and, if necessary, terminates the qualified professional;~~

26. Personal care services. (continued)

~~e) recruits, hires and, if necessary, terminates the personal care assistant;~~

~~f) with assistance from the qualified professional, orients and trains the personal care assistant;~~

~~g) with assistance as needed from the qualified professional or the recipient's physician, supervises and evaluates the personal care assistant;~~

~~h) monitors and verifies in writing the number of hours worked by the qualified professional and the personal care assistant; and~~

~~i) together with the PCA Choice provider, qualified professional, and personal care assistant, enters into a written agreement before services begin.~~

~~The agreement must include:~~

~~1) the duties of the recipient, PCA Choice provider, qualified professional, and personal care assistant;~~

~~2) the salary and benefits for the qualified professional and personal care assistant;~~

~~3) the administrative fee of the PCA Choice provider and services paid for with that fee, including background checks;~~

26. Personal care services. (continued)

~~4) procedures to respond to billing or payment complaints; and~~

~~5) procedures for hiring and terminating the qualified professional and personal care assistant.~~

~~The PCA Choice provider:~~

~~a) enrolls in medical assistance;~~

~~b) requests and secures background checks on qualified professionals and personal care assistants according to the state human services licensing act;~~

~~c) bills for personal care assistant and qualified professional services;~~

~~d) pays the qualified professional and personal care assistant based on actual hours of services provided;~~

~~e) withholds and pays all applicable federal and state taxes;~~

~~f) makes the arrangements and pays unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;~~

~~g) maintains the required statutory documentation of personal care assistant services in a recipient file, as well as evidence of compliance with personal care assistant training requirements and all notice to recipients regarding personal care~~

26. Personal care services. (continued)

~~assistant service use at a rate likely to exhaust authorized hours prior to the end of the authorization period; and~~

~~h) ensures arm's length transactions with the recipient and personal care assistant.~~

~~i) the organization shall comply with all laws and rules governing the provision of personal care assistant services.~~

~~At a minimum, qualified professionals visit the recipient in the recipient's home at least once every year. Qualified professionals report to the appropriate authorities any suspected abuse, neglect, or financial exploitation of the recipient.~~

~~As part of the assessment and reassessment process in item 6.d.B. of this attachment, the following must be met to use, or continue to use, a PCA Choice provider:~~

~~a) the recipient must be able to direct the recipient's own care, or the responsible party for the recipient must be readily available to direct the care of the personal care assistant;~~

~~b) the recipient or responsible party must be knowledgeable of the health care needs of the recipient and be able to effectively communicate those needs;~~

~~c) effective August 1, 2002, the recipient who receives shared personal care assistant services (shared services) must use the same PCA Choice provider; and~~

26. Personal care services. (continued)

~~d) a service update cannot be used in lieu of an annual reassessment.~~

~~Authorization to use the PCA Choice option will be denied, revoked, or suspended if:~~

~~a) the public health nurse or qualified professional determines that use of this option jeopardizes the recipient's health and safety;~~

~~b) the parties do not comply with the written agreement; or~~

~~c) the use of the option results in abusive or fraudulent billing.~~

~~The recipient or responsible party may appeal this decision. A denial, revocation or suspension will not affect the recipient's authorized level of personal care assistant services.~~

~~**C. Amount, duration and scope of personal care services:**~~

~~Department prior authorization is required for all personal care services and supervision services, if supervision is requested by the recipient or responsible party. Prior authorization is based on the physician's statement of need; the recipient's needs, diagnosis, and condition; an assessment of the recipient; primary payer coverage determination information as required; the service plan; and cost-effectiveness when compared to other care options. The Department may authorize up to the following amounts of personal care services:~~

26. Personal care services. (continued)

~~a) up to 2 times the average number of direct care hours provided in nursing facilities for the recipient's comparable case mix level;~~

~~b) up to 3 times the average number of direct care hours provided in nursing facilities for recipients with complex medical needs, or who are dependent in at least seven activities of daily living and need either physical assistance with eating or have a neurological diagnosis;~~

~~c) up to 60 percent of the average payment rate for care provided in a regional treatment center for recipients who exhibit, or that without supervision, observation, or redirection would exhibit, one or more of the following behaviors:~~

~~1) self-injury;~~

~~2) physical injury to others; or~~

~~3) destruction of property;~~

~~d) up to the amount medical assistance would pay for care provided in a regional treatment center for recipients referred by a regional treatment center preadmission evaluation team; or~~

~~e) up to the amount medical assistance would pay for facility care for recipients referred by a long-term care consultation team; and~~

26. Personal care services. (continued)

~~f) a reasonable amount of time for the provision of supervision of personal care assistant services, if a qualified professional is requested by the recipient or responsible party.~~

~~• Department prior authorization is also required if more than two reassessments to determine a recipient's need for personal care assistant services are needed during a calendar year.~~

~~• Personal care assistant services must be provided pursuant to a physician's statement of need. The statement of need must include the diagnosis or condition of the recipient and be updated when the recipient's medical condition requires a change, but at least annually if the need for services is ongoing. The service plan must be reviewed and revised as medically necessary at least once every 365 days.~~

~~For personal care assistant services:~~

~~a) effective July 1, 1996, 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;~~

~~b) effective July 1, 1996, if the recipient's medical need changes, the recipient's provider may request a change in service authorization; and~~

~~c) as of July 1, 1998, in order to continue to receive personal care assistant services after the first year, the recipient or the responsible party, in conjunction with the public health~~

26. Personal care services. (continued)

~~nurse, may complete a service update on forms developed by the Department. If a service update is completed, it substitutes for the annual reassessment described in item 6.d.B. of this attachment, except that PCA Choice consumers must have a face-to-face assessment at least annually.~~

- ~~Recipients or responsible parties utilizing either PCA Choice or PCA provider organizations have the choice to request qualified professional supervision or to supervise the PCA themselves. A reasonable amount of time for the provision of supervision shall be authorized.~~

- ~~Personal care assistant services are provided for recipients who live in their own home if their own home is not a hospital, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), institution for mental disease, or licensed health care facility.~~

- ~~Recipients may use approved units of service outside the home when normal life activities take them outside the home. Effective July 1, 1996, total hours for personal care assistant services, whether performed inside or outside a recipient's home, cannot exceed that which is otherwise allowed for personal care assistant services in an in-home setting.~~

- ~~Recipients may receive shared personal care assistant services (shared services), defined as providing personal care assistant services by a personal care assistant to two or three recipients at the same time and in the same setting. For purposes of this item, "setting" means the home or foster care home of one of the recipients, a child care program in~~

26. Personal care services. (continued)

~~which all recipients served by one personal care assistant are participating, which has state licensure or is operated by a local school district or private school, or outside the home or foster care home when normal life activities take recipients outside the home or foster care home. The provider must offer the recipient or responsible party the option of shared services; if accepted, the recipient or responsible party may withdraw participation in shared services at any time.~~

~~If supervision of a personal care assistant by a qualified professional is requested by any one of the recipients or responsible parties, the supervision duties of the qualified professional are limited to only those recipients who requested the supervision. In addition to the documentation requirements for personal care provider service records in state rule, a personal care provider must meet documentation requirements for shared services and must document the following in the health service record for each recipient sharing services:~~

~~a) permission by the recipient or responsible party for the maximum number of shared services hours per week chosen by the recipient;~~

~~b) permission by the recipient or responsible party for personal care assistant services provided outside the recipient's home;~~

~~c) permission by the recipient or responsible party for others to receive shared services in the recipient's home;~~

26. Personal care services. (continued)

~~d) revocation by the recipient or responsible party of the shared service authorization, or the shared service to be provided to others in the recipient's home, or the shared services to be provided outside the recipient's home;~~

~~e) if a qualified professional is requested by any one of the recipients or responsible parties, supervision of the shared personal care assistant services by the qualified professional, including the date, time of day, number of hours spent supervising the provision of shared services, whether the supervision was face-to-face or another method of supervision, changes in the recipient's condition, and shared services scheduling issues and recommendations;~~

~~f) if a qualified professional is requested by any one of the recipients or responsible parties, documentation by the qualified professional of telephone calls or other discussions with the personal care assistant regarding services being provided to the recipient; and~~

~~g) daily documentation of the shared services provided by each identified personal care assistant including:~~

~~1) the names of each recipient receiving shared services together;~~

~~2) the setting for the shared services, including the starting and ending times that the recipient received shared services; and~~

26. Personal care services. (continued)

~~3) notes by the personal care assistant regarding changes in the recipient's condition, problems that may arise from the sharing of services, scheduling issues, care issues, and other notes as required by the qualified professional, if a qualified professional is requested by any one of the recipients or responsible parties.~~

~~In order to receive shared services:~~

~~a) the recipient or responsible party, in conjunction with the county public health nurse, must determine:~~

~~1) whether shared services is an appropriate option based on the individual needs and preferences of the recipient; and~~

~~2) the amount of shared services allocated as part of the overall authorization of personal care assistant services;~~

~~b) the recipient or responsible party, in conjunction with the supervising qualified professional (if a qualified professional is requested by any one of the recipients or responsible parties), must arrange the setting and grouping of shared services based on the individual needs and preferences of the recipients;~~

~~c) the recipient or responsible party, and the supervising qualified professional (if a qualified professional is requested by any one of the recipients or responsible parties), must~~

26. Personal care services. (continued)

~~consider and document in the recipient's health service record:~~

~~1) the additional qualifications needed by the personal care assistant to provide care to several recipients in the same setting;~~

~~2) the additional training and supervision needed by the personal care assistant to ensure that the needs of the recipient are appropriately and safely met. If supervision by a qualified professional is requested by any one of the recipients or responsible parties, the provider must provide on-site supervision by a qualified professional within the first 14 days of shared services, and monthly thereafter;~~

~~3) the setting in which the shared services will be provided;~~

~~4) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting; and~~

~~5) a contingency plan that accounts for absence of the recipient in a shared services setting due to illness or other circumstances and staffing contingencies.~~

~~The following personal care assistant services are covered under medical assistance as personal care assistant services:~~

26. Personal care services. (continued)

~~a) services and supports that assist in accomplishing activities of daily living. "Activities of daily living" include eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning;~~

~~b) services and supports that assist in accomplishing instrumental activities of daily living. "Instrumental activities of daily living" include meal planning and preparation, managing finances, shopping for food, clothing and other essential items, performing essential household chores, communication by telephone and other media, and participating in the community;~~

~~c) services and supports that assist in health-related functions through hands-on assistance, supervision, and cuing. "Health-related functions" means services that can be delegated or assigned by a licensed health care professional to be performed by a personal care assistant. These are provided under the supervision of a qualified professional or the direction of the recipient's physician; and~~

~~d) redirection and intervention for behavior including observation and monitoring.~~

~~A recipient may choose the flexible use option, which is the scheduled use of authorized hours of personal care assistant services, which vary within a service authorization period of up to six months. Authorized hours not used within the six-month period may not be carried over to another time period.~~

26. Personal care services. (continued)

~~Under the flexible use option:~~

~~a) a recipient or responsible party, the public health nurse, and, if the recipient is receiving case management services, the case manager, determine whether the flexible use option is appropriate.~~

~~b) if appropriate, the persons listed in item a) must ensure that the allocation of hours covers the ongoing needs of the recipient over an entire year divided into two six-month periods of flexible use.~~

~~c) the Department will not authorize additional services to supplement a service authorization that is exhausted before the end date under this option, unless the public health nurse determines a change in condition and a need for increased services is established.~~

~~d) the personal care provider organization and the recipient or responsible party, or the PCA Choice provider, must develop a written month-to-month plan of the projected use of personal care assistant services that is part of the care plan and ensures:~~

~~1) that the health and safety needs of the recipient will be met;~~

~~2) that the total annual authorization will not be used before the end of the authorization period; and~~

26. Personal care services. (continued)

~~3) monthly monitoring will be conducted of hours used as a percentage of the authorized amount.~~

~~c) the provider must notify the recipient or responsible party, the public health nurse, and any case manager in advance, on a Department form, if the monthly amount of hours used is likely to exhaust authorized hours prior to the end of the authorization period.~~

~~f) the Department will provide written notice to the provider, the recipient or responsible party, the public health nurse, and any case manager, when a flexible use recipient exceeds the month-to-month projected use of personal care assistant services as determined by the Department. If the use of hours exceeds the monthly service authorization by this amount for two months during any three-month period, the Department will notify the recipient and the public health nurse that the flexible use authorization will be revoked beginning the following month. However, this revocation is not implemented if, within ten working days of the Department's notice, the public health nurse requests prior authorization (which cannot exceed 45 days) for a temporary increase in the service authorization or continuation of the flexible use option, or the recipient appeals and services pending appeal is are ordered. The denial or revocation of the flexible use option does not affect the recipient's authorized level of personal care assistant services.~~

~~g) the recipient or responsible party may stop the flexible use of hours at any time.~~

26. Personal care services. (continued)

~~The following services are **not covered** under medical assistance as personal care assistant services:~~

~~a) health services provided and billed by a provider who is not an enrolled personal care provider;~~

~~b) personal care assistant services that are provided by the recipient's spouse, legal guardian, parent of a recipient under age 18, or the recipient's responsible party;~~

~~c) effective July 1, 1996, services provided by a foster care provider of a recipient who cannot direct his or her own care, unless a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met;~~

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

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

~~f) sterile procedures;~~

~~g) giving of injections of fluids into veins, muscles, or skin;~~

~~h) homemaker services that are not an integral part of a personal care assistant service;~~

~~i) home maintenance or chore services;~~

26. Personal care services. (continued)

~~j) personal care assistant services when the number of foster care residents is greater than four;~~

~~k) personal care assistant services when other, more cost-effective, medically appropriate services are available;~~

~~l) services not specified as covered under medical assistance as personal care assistant services;~~

~~m) effective January 1, 1996, assessments by personal care provider organizations or by independently enrolled registered nurses;~~

~~n) effective July 1, 1996, services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care assistant, unless case management is provided (applies to foster care settings);~~

~~o) effective January 1, 1996, personal care assistant services that are not in the service plan;~~

~~p) home care services to a recipient who is eligible for Medicare covered home care services (including hospice), if elected by the recipient, or any other insurance held by the recipient;~~

~~q) services to other members of the recipient's household;~~

~~r) any home care service included in the daily rate of the community-based residential facility where the recipient resides;~~

~~s) personal care assistant services that are provided without a physician's statement of need in the personal care provider agency's or PCA Choice provider's recipient file; or~~

~~t) services not authorized by the commissioner or the commissioner's designee.~~

26. Personal care services, continued, continued.

I. **Personal care services**

A. Personal care services include:

1. Assistance in **activities of daily living** including eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning;
2. Assistance in **health-related procedures and tasks** per state law including services that can be delegated or assigned by a licensed health care professional to be performed by a personal care assistant, under the supervision of a qualified professional or the direction of the recipient's physician. A licensed health care professional includes a registered nurse, physician, nurse practitioner, and physician assistant;
3. **Observation and redirection of behaviors**; and
4. Assistance in **instrumental activities of daily living** including meal planning and preparation; assistance with paying bills; shopping for food, clothing and other essential items; performing essential household tasks integral to personal care services; communication by telephone and other media; and traveling to medical appointments and to participate in the community. Traveling includes time to accompany the recipient according to the recipient's care plan.

B. Personal care services are provided as follows:

1. Personal care services are provided for recipients who live in their own home if their own home is not a hospital, nursing facility, intermediate care facility for persons with mental retardation (ICF/MR), institution for mental disease, or licensed health care facility.
2. Recipients may use approved units of personal care service outside the home when normal life activities take them outside the home.
3. Personal care services are provided to a recipient who is able to direct his or her own care or to a recipient for whom there is a **responsible party** if the recipient cannot direct his or her own care.
   a. A **responsible party** is a person who:
      i. is knowledgeable about the health care needs of the recipient and is able to effectively communicate those needs;
      ii. provides the support necessary to assist the recipient to live in the community;
      iii. is at least 18 years old;

26. Personal care services, continued, continued.

iv. actively participates in planning and directing personal care services;
v. is not the personal care assistant for the recipient, an owner or employee of a personal care provider agency or county staff acting as part of county employment;
vi. enters into a written agreement with a personal care assistance provider agency on a form determined by the commissioner to perform the duties of the responsible party.

b. A responsible party is required for all recipients when:
i. the recipient is a minor
ii. the recipient is an incapacitated adult with a court-appointed guardian;
iii. the assessment determines a recipient cannot direct their own care and is in need of a responsible party

II. **Provider Qualifications and training**

A. Personal care services are provided by **personal care provider agencies**

1. A **personal care provider agency** means a medical assistance enrolled provider that provides or assists with providing personal care assistance services and includes:
a. Personal care assistance provider agency;
b. Personal care assistance choice agency.

B. Personal care provider agencies must provide the following submissions for initial and ongoing enrollment:

1. Basic agency contact information;
2. Proof of a surety bond, fidelity bond, workers compensation insurance, and liability insurance;
3. Description of the agency's organization and employees identifying all owners, managing employees, board of directors, and the affiliations of the directors, owners, and staff to other service providers;
4. Documentation of compliance with background studies

26. Personal care services, continued, continued.

5. Written policies including employee policies, service delivery policies and grievance policies;
6. Copies of forms used for daily business;
7. Documentation of trainings staff are required to attend;
8. Documentation of completion of required training;
9. Documentation of the agency's marketing practices;
10. Disclosure of ownership, leasing, or management of all residential properties;
11. Documentation of completion of OHS mandatory training by owners, all managing employees, and qualified professionals.

C. Personal care provider agency general duties

1. Pay the staff based on actual hours of services provided
2. Withhold and pay all applicable federal and state taxes
3. Report all suspected neglect and abuse to the appropriate reporting center intake. ~~common entry point, which is an entity in each county serving as a 24 hour intake system for reports of potential abuse and maltreatment.~~
4. Provide the recipient with a copy of the Home Care Bill of Rights at start of service
5. Request reassessments at least 60 days prior to the end of the recipient's current authorization period.
6. Provide training for the personal care assistant based on the assessed needs of the recipient;
7. Provide training about care of a person who is ventilator- dependent, if appropriate.

D. Personal care provider agency criminal background studies

1. The following are required to have successfully completed criminal background studies:
   a. owners who have a five percent interest or more
   b. all managing employees as defined in 42 CFR §455.101
   c. qualified professionals as defined on page 78y
   d. personal care assistants

26. Personal care services, continued

2. A personal care provider agency is barred from enrollment if:
   a. The organization has not initiated background studies on owners and managing employees; or
   b. The organization has initiated background studies on owners and managing employees, but the commissioner has sent the organization a notice that an owner or managing employee of the organization has been disqualified and the owner or managing employee has not received a set aside of the disqualification.

3. Before a qualified professional who works for a personal care assistance provider agency provides services, the personal care assistance provider agency must initiate a background study on the qualified professional, and the personal care assistance provider agency must have received a notice from the commissioner that the qualified professional is:
   a. Not disqualified; or
   b. Disqualified, but the qualified professional has received a set aside of the disqualification.

4. Before a personal care assistant employed by a personal care assistance provider agency is enrolled with the department and provides services for a recipient, a background study must be initiated, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:
   a. Not disqualified;
   b. Disqualified, but the personal care assistant has received a set aside of the disqualification; or

   In the event that a personal care agency discontinues service provision or is disenrolled, a recipient's enrolled personal care attendant can continue to assist the recipient until such time that another background study can be conducted at another provider agency in order to ensure continuity of services and to protect the health and safety of the recipient.

26. Personal care services, continued

E. **Personal care Assistance Choice** option

1. "Personal Care Assistance Choice" is a consumer-directed personal care service option that allows recipients to recruit, hire, terminate, train and supervise their personal care assistants.
2. The enrollment requirements, general duties and policies governing personal care described on pages 78u~~v~~ ~~and~~ through 78w apply to the Personal Care Assistance Choice Option with the following exceptions:
   a. Annual assessments of recipients must be face-to-face.
   b. Personal Care Assistance Choice provider agencies provide fiscal intermediary services which include administrative and financial responsibilities including collection of time cards, billing for services and payment to staff.
   c. The recipient and the Personal Care Assistance Choice provider agency must enter into a written agreement that includes the following components:
      i. Duties of the recipient, qualified professional personal care assistant, and agency
      ii. Salary and benefits
      iii. Administrative fee of the Personal Care Assistance Choice provider agency and services paid for with that fee
      iv. Grievance procedures to respond to complaints
      v. Procedures for hiring and terminating the personal care assistant
      vi. Documentation requirements
   d. The recipient is responsible for training the personal care assistant on his/her individual needs for assistance and for development of a care plan.
   e. If using the shared service option, the recipients may use only one Personal Care Assistance Choice provider agency.
   f. The Personal Care Assistance Choice provider agency must be the employer of personal care assistants and qualified professionals, subject to state employment law and related regulations;
   g. The Personal Care Assistance Choice provider agency owners and managing employees must not be related as a parent, child, sibling, or spouse to the recipient, responsible party, ~~qualified professional,~~ or the personal care assistant;

26. Personal care services, continued

a. The Personal Care Assistance Choice provider agency must ensure arms-length transactions without undue influence or coercion with the recipient and personal care assistant.

3. Under Personal Care Assistance Choice, qualified professionals must visit the recipient in the recipient's home at least once every 180 days, unless the recipient meets the exception criteria listed below in Section E. ~~These visits may be conducted remotely using telephonic or other electronic means.~~

4. Authorization to use the Personal Care Assistance Choice option will be denied, revoked, or suspended if:

a. the public health nurse or qualified professional, as defined below in F.1., determines that use of this option jeopardizes the recipient's health and safety;

b. the parties do not comply with the written agreement; or

c. the use of the option results in abusive or fraudulent billing.

E. **Qualified Professionals**

1. "Qualified professional" means the following professionals ~~as defined in Minnesota Statute § 256b.0625, subdivision 19c'~~ employed by a personal care provider agency: a registered nurse, mental health professional, licensed social worker, or qualified developmental disability specialist.

2. A qualified professional performs the duties of training, supervision, and evaluation of the personal care assistance staff and evaluation of the effectiveness of personal care services. The qualified professional develops a care plan based on the service plan developed by the assessor.

3. Recipients or responsible parties utilizing either Personal Care Assistance Choice or personal care provider organizations must have qualified professional supervision of personal care assistants. Supervision may be conducted remotely if the recipient's primary health care provider has documented that remote supervision is appropriate due to the recipient's chronic health condition or severely compromised immune system.

4. Qualified professionals must report to the appropriate reporting center intake ~~authorities~~ any suspected abuse, neglect, or financial exploitation of the recipient.

G. **Personal Care Assistants**

1. Must be at least 18 years of age, except that a 16 or 17 year old may be a personal care assistant if they meet all of the requirements for the position, have supervision every 60 days, and are employed by only one personal care provider agency;

26. Personal care services, continued

2. Must be employed by a personal care provider agency;
3. Must enroll with the department after clearing a criminal background study;
4. Must effectively communicate with the recipient and personal care provider agency;
5. Must provide covered services according to the care plan, respond appropriately to recipient needs, and report changes to the physician or the qualified professional;
6. Must not be a consumer of personal care services;
7. Must maintain daily written records;
8. Must report any suspected abuse, neglect or financial exploitation of the recipient to appropriate authorities;
9. Must complete standardized training.

III. **Amount, duration and scope of personal care services**

A. Assessment and Service Plan

1. A personal care service plan must be developed at least once every 365 days following an assessment by a public health nurse, or a long term care consultation, which is an assessment of level of care and care planning for purposes of home and community-based waiver programs.
2. If the recipient's medical need changes, the recipient's personal care provider agency may request a change in service authorization or make a referral to another service.
3. In order to continue to receive personal care services after the first year, a service update may be completed. If a service update is completed, it substitutes for the annual reassessment described in item 6.d.B. of this Attachment, except that Personal Care Assistance Choice consumers must have a face-to-face assessment at least annually.

B. Department authorization

1. The Department authorizes all personal care services and supervision services.
2. Authorization is based on the recipient's needs, diagnosis, and condition; an assessment of the recipient; primary payer coverage determination information as required; the service plan; and cost effectiveness when compared to other care options.
3. The Department authorizes total daily personal care services based on the following:

26. Personal care services, continued

a. The person meets the access criteria of having a dependency in an activity of daily living or having the presence of specific behaviors including physical aggression towards self or others, or destruction of property;
b. A person who meets the access criteria above with fewer than two dependencies in activities of daily living is authorized 30 minutes of personal care.
c. A person who has two or more dependencies in activities of daily living is authorized for personal care as follows:
   i. The person has been given a home care rating and assigned a daily base amount of time by identifying the number of dependencies in activities of daily living, the presence of complex health related needs and/or the presence of specific behaviors including physical aggression towards self or others, or destruction of property;
   ii. The person is authorized for additional time as follows:
      - 30 additional minutes per day for a dependency in each of the critical activities of daily living of eating, transferring, mobility, and toileting;
      - 30 additional minutes per day for each complex health-related need;
      - 30 additional minute per day for each identified behavior description.

4. For people who meet the definition of ventilator-dependent, the Department authorizes a combination of personal care assistance~~,~~ and private duty nursing as defined in item 8, ~~and services provided by Medicare Certified Home Health Agencies as defined in items 7, 7.a. and 7.b.,~~ up to the ~~limit~~amount the Department would pay for ~~all direct care services provided in-home that would be included in the payment for care at a hospital;~~ 24 hours per day of private duty nursing at the highest cost level;
5. The Department authorizes a reasonable amount of time for qualified professional supervision of personal care services;
6. Department authorization is also required if more than two reassessments are needed during a calendar year to determine a recipient's need for personal care assistant services.

26. Personal care services, continued

C. **Shared Service Option**

1. **"Shared Service Option"** means personal care services provided in the same setting at the same time by the same personal care assistant for two or three recipients, including recipients selecting PCA Choice, who have entered into an agreement to share services,
2. The shared service option must be appropriate based on the ages of the recipients, compatibility, and coordination of their assessed care needs. A contingency plan must be developed that accounts for absence of a recipient in a shared services agreement due to illness or other circumstances.
3. The shared service option is elected by the recipient or responsible party. The recipient or responsible party may withdraw participation in shared services at any time.
4. There must be documentation of the shared services in each recipient's health record including the training of the personal care assistant, number of hours/units shared, setting, and supervision of staff and services.
5. Each recipient sharing service must use the same personal care assistance provider agency.

D. Flexible Use of Personal Care Services

1. "Flexible Use" means the scheduled use of authorized hours of personal care services, which vary within a service authorization period of up to six months. The recipient/responsible party determines the schedule and communicates this to the personal care provider agency.
2. All recipients, except those assigned to the Minnesota Restricted Recipient program or who have the flexible use option revoked by the Department for misuse or abuse, may use their personal care services hours/units in a flexible manner to meet their needs within the following limits:
    a. Total authorized hours/units must be divided between two six-month date spans.
    b. No more than 75% of total authorized hours/units may be used in a six-month date span.
    c. Health and safety must be assured.
    d. Units cannot be transferred from one six-month date span to another.
    e. Additional PCA hours/units cannot be added unless there is a change in condition.

26. Personal care services, continued

3. The personal care provider agency qualified professional and the recipient or responsible party must develop a written month-to month plan of the projected use of personal care assistant services that is part of the care plan and ensures the:
   a. Health and safety needs of the recipient are met throughout both six-month authorization periods; and
   b. Total hours will not exceed total hours authorized.
4. The provider agency shall monitor the use of personal care assistance services to ensure health and safety needs of the recipient are met throughout the authorization periods.
5. The Department will provide written notice to the provider and the recipient or responsible party when the recipient is at risk of exceeding the personal care assistance services prior to the end of the six-month date span.
6. The Department may take actions if there is misuse and abuse of flexible use of personal care services including, but not limited to:
   a. Revoking flexible use by limiting the authorization period to one month;
   b. Requiring a recipient to have a responsible party;
   c. Requiring a qualified professional to monitor and report services on a monthly basis.

26. Personal care services, continued

IV. Services not covered under medical assistance as personal care services

A. Health services provided and billed by a provider who is not an enrolled personal care provider;

B. Personal care services that are provided by the ~~recipient's spouse~~ parent, stepparent, or ~~paid~~ legal guardian of a recipient under age 18, ~~parent of a recipient under age 18~~a paid legal guardian of a recipient over age 18, or the recipient's spouse or responsible party;

C. Services that are used solely as a child care or babysitting service;

D. Services provided by the residential or program license holder in a residence licensed for more than four persons;

E. Services that are the responsibility or in the daily rate of a residential or program license holder under the terms of a service agreement and administrative rules;

F. Sterile procedures;

G. Giving of injections of fluids into veins, muscles, or skin;

H. Homemaker services that are not an integral part of a personal care service;

I. Home maintenance or chore services;

J. Personal care services when other, more cost-effective, medically appropriate services are available;

K. Services that are not in the individual's service plan;

L. Home care services to a recipient who is eligible for Medicare covered home care services (including hospice), if elected by the recipient, or any other insurance held by the recipient;

M. Services to other members of the recipient's household;

N. Services not specified as covered under medical assistance as personal care assistant services;

O. Application of restraints;

P. Assessments by personal care provider organizations or by independently enrolled registered nurses;

Q. Services provided in lieu of legally required staffing in a residential or child care setting; and

R. Services not authorized by the commissioner or the commissioner's designee.

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 5 to this Attachment.

- Not provided.

28. Freestanding Birth Center services.

Freestanding birth center means a facility licensed as a birth center under Minnesota law that is not a hospital or licensed as part of a hospital.

The following items and services are included in the freestanding birth center facility services payment:

1) Birthing center facility services
2) Nursery care facility services

Services in freestanding birth centers are provided by certified nurse midwives as described in item 17 and traditional nurse midwives providing traditional midwifery services.

Traditional midwifery services are limited to:

1) services performed by a licensed traditional midwife in a licensed birth center; and

2) the types of services within the scope of practice of traditional midwifery under state statute or rule.

29. **Integrated Care Models (FFS Primary Care Case Management)**

Integrated Health Partnership (IHP). IHP entities provide FFS primary care case management services under authority of§ 1905(t) of the Social Security Act, which includes location, coordination and monitoring of health care services. The state ensures that it will comply with the applicable beneficiary protections in§ 1905(t)(3)as described below. IHP entities are under contract to share cost and savings gained or lost on the total cost of care for certain services provided on a fee-for-service (FFS) basis. Beginning January 1, 2018, Track 1 and Track 2 IHP entities will receive population-based payments for the provision of evaluation, intervention, and health improvement activities of its attributed patients.

Medical assistance beneficiaries are free to choose from any qualified provider, and IHP entities are not under contract to provide medical assistance covered services for a fixed price. Providers who are participating with IHP entities will provide services and submit claims in accordance with fee-for-service requirements.

~~Legacy IHP entities are those with contracts that began before January 1, 2018, and include both virtual and integrated models.~~ Track 1 and track 2 IHP entities ~~differ from legacy IHPs based on~~ have the following characteristics: ~~1)~~ track 1 & 2 IHPs have contracts that begin January 1, 2018, or after, and ~~2)~~ they have ~~also~~ agreed to be evaluated on utilization and health equity metrics. Additionally, b~~B~~oth track 1 and track 2 IHP entities will receive population-based payments.~~; a~~A track 2 entity differs from a track 1 entity because of its ability to manage the risk of loss. Track 2 IHP entities will share costs and savings gained or lost on the total cost of care for certain services provided on a fee-for-service basis.

IHP entities must be under contract with the state and have demonstrated through the procurement process that:

- The delivery system includes or coordinates the full scope of primary care services;
- Methods and approaches are in place to coordinate care across the spectrum of services included in the payment model;
- Partnerships are in place between the IHP entity and community-based organizations and public health resources will be in place;
- A process is in place to engage patients and their families meaningfully in the care they receive;
- The delivery system has the capacity to receive data from the state via secure electronic processes;

29. **Integrated Care Models (FFS Primary Care Case Management)**

- The delivery system uses data provided by the state to identify opportunities for beneficiary engagement and to stratify their population to determine the care model strategies needed to improve outcomes;

- The delivery system coordinates care with other medical providers who are responsible for pertinent aspects of care; and

- The delivery system participates in quality measurement activities as required by the state and engages in quality improvement activities.

The following beneficiary protections in § 1905(t) apply to this project in the following manner:

- § 1905(t)(3)(A), which requires primary care case managers to maintain reasonable hours of operation and 24-hour availability of referral and treatment, is met because beneficiaries are afforded free choice of providers participating in Medical Assistance;

- § 1905(t)(3)(B), which restricts enrollment to nearby providers, does not apply to this project because there is no enrollment in the project;

- § 1905(t)(3)(C), which requires primary care case managers to ensure the availability of a sufficient number of health care professionals to provide high quality care in a prompt manner, is met in that beneficiaries are afforded free choice of providers participating in Medical Assistance; and in that the attribution methodology ensures that only patients who have a relationship with the participating providers are attributed to the IHP entity;

- § 1905(t)(3)(D), which prohibits discrimination on the basis of health status in enrollment and disenrollment, is met because qualified IHP entities will be prohibited by contract from activities designed to result in selective recruitment and attribution of individuals with more favorable health status.

29. **Integrated Care Models (FFS Primary Care Case Management)**

- § 1905(t)(3)(E), which provides for beneficiary's right to terminate enrollment, does not apply to this project;

- § 1905(t)(3)(F), which requires compliance with § 1932, is applicable to this project as follows:

    - §1903(d)(1), which provides for protections against fraud and abuse, is met in that all providers participating in IHP are enrolled in the Medical Assistance program and bound by the rules of the program;

    - §1932(d)(2), which includes restrictions on marketing by managed care entities, requires the state to monitor marketing efforts on the part of IHP entities; and

    - §1932(e)(4) requires the states to retain the ability to terminate the contract with the IHP entities for failure to meet the terms of the contract.

Qualified IHP ~~demonstration~~ program provider organizations are those that have submitted successful responses to the Department's request for proposals and are under contract with the state to participate in this ~~demonstration~~program, ending three or more years following the ~~implementation~~execution date of the contract.

~~The state will notify Medical Assistance beneficiaries of the program, including a description of how personal information will be used, and payment incentives, through an annual mailing by May 1 of each performance year, to those beneficiaries who are attributed to the IHP entity at that point in time.~~

The state will ensure Medical Assistance beneficiaries are notified of the information outlined in paragraphs (e) and (f) of 42 CFR §438.10 via written or electronic means.

SUPPLEMENTARY NOTES

The following services are not covered under the Medical Assistance program:

1. a health service paid for directly by any other source, including third-party payers and recipients, unless the recipient's eligibility is retroactive and the provider bills the Medical Assistance program for the purpose of repaying the recipient;

2. drugs that are not in the Drug Formulary or, which have not received prior authorization;

3. a health service for which the required prior authorization was not obtained;

4. autopsies;

5. missed or canceled appointments;

6. telephone calls or other communications that were not face-to-face between the provider and the recipient. This does not apply to ~~skilled nurse visits via telehome care and~~ telemedicine services, or oral language interpreter services to persons with limited English proficiency;

7. reports required solely for insurance or legal purposes unless requested by the local agency or the Department;

8. an aversive procedure, including cash penalties from recipients, unless provided according to state rules;

9. a health service that does not comply with Minnesota Rules, parts 9505.0170 to 9505.0475

10. separate charges for the preparation of bills;

11. separate charges for mileage for purposes other than medical transportation of a recipient;

12. a health service that is not provided directly to the recipient, unless the service is a covered service;

SUPPLEMENTARY NOTES (continued)

13. concurrent care by more than one provider of the same type of provider or health service specialty, for the same diagnosis, without an appropriate medical referral detailing the medical necessity of the concurrent care, if the provider has reason to know concurrent care s being provided. In this event, the Department shall pay the first submitted claim;

14. a health service, other than an emergency health service, provided to a recipient without the knowledge and consent of the recipient or the recipient's legal guardian, or a health service provided without a physician's order when the order is required by state rules, or a health service that is not in the recipient's plan of care;

15. a health service that is not documented in the recipient's health care record or medical record as required by state rules;

16. a health service other than an emergency health service provided to a recipient in a long-term care facility that is not in the recipient's plan of care or has not been ordered, in writing, by a physician when an order is required;

17. an abortion that does not comply with 42 CFR §§441.200 through 441.208 or Minnesota Statutes, §256B.0625, subdivision 16;

18. a health service that is of a lower standard of quality than the prevailing community standard of the provider's professional peers. In this event, the provider of service of a lower standard of quality is responsible for bearing the cost of the service;

19. a health service that is only for a vocational purpose or an educational purpose that is not related to a health service;

20. except for an emergency, more than one consultation by a provider per recipient per day; for purposes of this item, "consultation" means a meeting of two or more physicians to evaluate the nature and progress of disease in a recipient and to establish the diagnosis, prognosis, and therapy;

SUPPLEMENTARY NOTES (continued)

21. except for an emergency, or as specified in the recipient's plan of care, more than one office, hospital, long-term care facility, or home visit by the same provider per recipient per day;

22. more than one home health aide visit per recipient per day, and more than two skilled nurse visits per recipient per day, except as specified in the recipient's plan of care;

23. record keeping, charting, or documenting a health service related to providing a covered service;

24. services for detoxification that are not medically necessary to treat an emergency;

25. artificial insemination;

26. reversal of voluntary sterilization;

27. surgery primarily for cosmetic purposes; and

28. ear piercing; ~~and~~

29. ~~sex reassignment surgery~~

30. Effective July 1, 2007, circumcision, unless the procedure is medically necessary.

31. Effective October 1, 2005, payment for visits to a hospital emergency room, that are coded as such visits, which are not for emergency and emergency post-stabilization care or urgent care.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: MINNESOTA

MENTAL HEALTH TARGETED CASE MANAGEMENT SERVICES

A. Target Group (section 1915(g) of the Act):

Case management services are available for individuals who have been determined to have serious and persistent mental illness or severe emotional disturbance.

Serious and persistent mental illness is defined as the condition of a person who has a mental illness and meets at least one of the criteria in items 1 to 5:

1. The person has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months; or

2. The person has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months; or

3. The person has a diagnosis of schizophrenia, bipolar disorder, major depression, schizoaffective disorder, or borderline personality disorder, indicates a significant impairment in functioning, and has a written opinion from a mental health professional (defined in item 6.d.A. of this attachment), in the last three years, stating that the person is reasonably likely to have future episodes requiring inpatient or residential treatment of a frequency described in items 1 and 2, unless ongoing case management or community support services are provided; or

4. In the last three years, the person has been committed by a court as a mentally ill person under Minnesota Statutes, chapter 253B or the person's commitment has been stayed or continued for reasons related to the person's mental illness; or

5. The person: (a) was eligible under items 1 to 4, but the specified time period has expired or the person was eligible as a child with severe emotional disturbance under Minnesota Statutes, §245.4871, subdivision 6; and (b)has a written opinion from a mental health professional, in the last three years, stating that the person is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in item 1 or 2, unless ongoing case management or community support services are provided.

A. Target group (section 1915(g) of the Act): (continued)

6. The person was eligible as a child with severe emotional disturbance and is age 21 or younger.

Severe emotional disturbance is defined as a child under age 18 who has an emotional disturbance and who meets one of the following criteria:

1. The child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance; or

2. The child is a Minnesota resident and is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact; or

3. The child has one of the following as determined by a mental health professional (defined in item 6.d.A. of this attachment):
   i. psychosis or a clinical depression; or
   ii. a risk of harming self or others as a result of an emotional disturbance; or
   iii. psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year; or

4. The child, as a result of an emotional disturbance, has significantly impaired home, school, or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.

B. Areas of the State in which services will be provided:

_x_ Entire state.

Only in the following geographic areas (authority §1915(g)(1) of the Act is invoked to provide services less than statewide): N/A

C. Comparability of Services:

___ Services are provided in accordance with §1902(a)(10)(B) of the Act.

_X_ Services are not comparable in amount, duration, and scope. Authority of §1915(g)(1) of the Act is invoked to provide services without regard to the requirements of §1902(a)(10)(B) of the Act.

D. Definition of Services:

Case management services are activities that are coordinated on an individual client basis and are designed to help persons with serious and persistent mental illness or severe emotional disturbance in gaining access to needed medical, social, educational, financial, or other services necessary to meet the client's needs.

Case Management services include:

1. Completion and regular review of a written functional assessment.

2. The development and regular review of a written individual community support plan for the client based on both a functional and a diagnostic assessment of the client and incorporating the client's individual treatment plans.

3. Assisting the client to access appropriate mental health or other service providers, consistent with §1902(a)(23) of the Act.

4. Coordination of the provision of services consistent with §1902(a)(23) of the Act.

5. Monitoring the client's progress and the effectiveness of the individual community support plan.

6. Monitoring the discharge planning process for a client being discharged from a residential treatment facility, regional treatment center, or inpatient hospital.

D. Definition of Services: (continued)

The monthly payment is limited to the following components of case management services:

1. At a minimum, in order to receive payment:

A. for an adult, the case manage~~mentr - service provider~~, must document at least a~~÷~~ contact with the adult or the adult's ~~client or the client's~~ legal guardian~~representative~~, which may occur via telephone, interactive video, or in person

B. For a child, the case management service provider must document at least face-to-face contact or contact via interactive video with the child, the child's parent or legal representative.

2. Contacts between the case manager or case manager associate and their clinical supervisor concerning the client.

3. Development, review, and revision of the client's Individual community support plan and functional assessment.

4. Time spent by the case manager or case manager associate traveling to meet face-to-face with a client who resides outside of the county of financial responsibility, or to meet face-to-face with the client's family, legal representative, or primary caregiver.

5. Time spent by the case manager or case manager associate traveling within the county of financial responsibility to meet face- to-face with the client or the client's family, legal representative, or primary caregiver.

D. **Definition of Services** (continued)

The above components of case management services must fall within the following parameters to be eligible for medical assistance ~~payment~~ coverage:

1. For clients in hospitals, NFs, or ICFs/~~MR~~ID, ~~payment~~ coverage for case management services is limited to the last 180 consecutive days before discharge in an effort to establish continuity of care and community-based services recommended by the discharge planning team. This 180-day coverage may not exceed more than six months in a calendar year.

Case management services will not duplicate those provided as part of the institution's discharge plan.

Case management services are not provided to individuals who are inmates of public institutions, or to individuals between the ages of 22 and 64 who are residing in an IMD.

2. A client's continued eligibility for case management services must be determined every 36 months by the local agency. The determination of whether the client continues to have a diagnosis of serious and persistent mental illness or severe emotional disturbance must be based on updating the client's diagnostic assessment or on the results of conducting a complete diagnostic assessment because the client's mental health status or behavior has changed markedly.

The following services are not eligible for ~~payment~~ coverage as case management services:

1. Diagnostic assessment.

2. Administration and management of a client's medications.

3. Legal services, including legal advocacy, for the client.

4. Information and referral services that are part of a county's community social service plan.

5. Outreach services including outreach services provided through the community support services program.

6. Services that are not adequately documented, as required under Minnesota Statutes ~~Rules, part 9520.0920, subpart 1~~.

D. Definition of Services: (continued)

7. Services that are otherwise eligible for payment on a separate schedule under Minnesota Rules, parts 9505.0170 to 9505.0475 or other rules of the Department.

8. Therapy or treatment services.

E. Qualifications of Providers:

A **case management service provider** must be:

1. A local agency, defined as a county or multi-county agency that is authorized under state law as the agency responsible for determining eligibility for the Medical Assistance Program. As the local mental health authority, the local agency is responsible for assuring that persons have access to mental health and other services, consistent with §1902(a)(23) of the Act;

2. An entity under contract with the local agency to provide case management services;

3. An entity meeting program standards set out in rules governing family community support services for children with severe emotional disturbance (when these standards meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 [governing case management for children with severe emotional disturbance] and 9505.0322, excluding subparts 6 [mental health case management services] and 10 [limitations on payment]);

4. A facility of the Indian Health Service or a facility owned or operated by a tribe or tribal organization and funded by Title I of the Indian Self-Determination and Education Assistance Act, P.L. 93-638 or Title V of the Indian Self-Determination and Education Assistance Act, P.L. 106-260 (formerly Title III of P.L. 93-638), operating as a 638 facility; or

5. An entity under contract with a facility of the Indian Health Service or a 638 facility.

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E. Qualifications of Providers: (continued)

1. **Case managers.** The following are considered case managers.

A. Mental health professionals as defined in item 6.d.A. and mental health practitioners as defined in item 13.d. of this attachment. Case management supervisors must also meet the criteria for mental health professionals.

B. Individuals who:

(1) are skilled in the process of identifying and assessing a wide range of client needs;

(2) are knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) (a) hold a bachelor's degree in one of the behavioral sciences or related fields including, but not limited to, social work, psychology, or nursing from an accredited college or university, or

(b) (1) have at least three or four years of experience as case manager associates;

(2) are registered nurses with a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community, discharge planning in a mental health -- setting totaling three years; or

(3) qualified before July 1, 1999, as case managers under provisions covering Department recognition of individuals without bachelor's degrees who had 40 hours of approved training in case management skills and at least 6,000 hours of supervised experience in the delivery of mental health services; and,

(4) if providing case management services to children, have experience and training in working with children.

E. Qualifications of Providers: (continued)

- Case managers with at least 2,000 hours of supervised experience in the delivery of services to adults or children must receive regular ongoing supervision and clinical supervision totaling 38 hours per year, of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The remainder may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours. Clinical supervision must be documented in the recipient's record.

- Case managers without 2,000 hours of supervised experience in the delivery of mental health services to adults with mental illness or to children with severe emotional disturbance must begin 40 hours of training approved by the Department of Human Services in case management skills and in the characteristics and needs of adults with serious and persistent mental illness or children with severe emotional disturbance. Case managers must also receive clinical supervision regarding individual service delivery from a mental health professional at least one hour per week until the requirement of 2,000 hours of experience is met.

- A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in mental illness, severe emotional disturbance and mental health services ~~annually~~ every two years.

2. **Case manager associates.** A case manager associate must:

   A. work under the direction of a case manager or case management supervisor;

   B. be at least 21 years of age;

   C. have a high school diploma or equivalent; and

   D. meet one of the following:

      (1) have an associate of arts degree in one of the behavioral sciences or human services;

E. Qualifications of Providers: (continued)

(2) be a registered nurse without a bachelor's degree;

(3) within the previous ten years:

(a) if providing case management services to adults, have three years of life experience With serious and persistent mental illness or as a child had severe emotional disturbance; or

(b) if providing case management services to adults or children, have three years of life experience as a primary caregiver to an adult with serious and persistent mental illness or to a child with severe emotional disturbance;

(4) have 6,000 hours work experience as a nondegreed state hospital technician; or

(5) meet the criterion in state law for mental health practitioner: have at least 6,000 hours of supervised experience in the delivery of services to persons with mental illness.

- Individuals meeting one of the criteria in (1) to (4) above may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in (5) may qualify as a case manager after three years of supervised experience as a case manager associate.

- Case manager associates must meet the following supervision, mentoring, and continuing education requirements:

(a) have 40 hours of preservice training as described on page 8 of this item for case management for clients with serious and persistent mental illness or for children with severe emotional disturbance;

E. Qualifications of Providers: (continued)

(b) receive at least 40 hours of continuing education in mental illness or severe emotional disturbance, and mental health services annually; and

(c) receive at least five hours of mentoring per week from a case management mentor. For purposes of this item, "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision to one or more case manager associates. Mentoring may occur while providing direct services to clients in the office or in the field and may be provided to a case manager associate or to a group of case manager associates. At least two mentoring hours per week must be individual and face-to-face.

3. **Others.**

An immigrant who is neither a case manager nor a case manager associate may provide case management services to adult immigrants with serious and persistent mental illness or to children with severe emotional disturbance who are members of the same ethnic group if the immigrant:

A. is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university;

B. completes 40 hours of training; and

C. for case management services to clients with serious and persistent mental illness, receives clinical supervision at least once a week until he or she becomes a case manager or case manager associate; or

D. for case management services to children with severe emotional disturbance, receives clinical supervision at least once a week until he or she receives a bachelor's degree and 2,000 hours of supervised experience.

F. Freedom of Choice:

The State assures that the provision of case management services will not restrict an individual's free choice of provider in violation of §1902(a)(23) of the Act, except as provided for under §1915(g)(1) of the Act.

1. Eligible recipients' choice of providers of case management services will be limited under §1915(g)(1) to providers defined and described in item E, above.

2. Eligible recipients will have free choice of the providers of other medical care under the State plan.

G. Payment:

Payment for case management services under the State plan is made on a monthly basis and does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

1. Services that are otherwise eligible for payment on a separate schedule under Minnesota Rules, parts 9505.0170 to 9505.0475, or other rules of the Department, are not eligible for payment as case management services.

2. Persons who are receiving home and community-based services under a waiver granted pursuant to §1915(c) of the Act are not eligible to receive the case management services described in this supplement if the services duplicate each other.

3. Persons who are receiving case management services through the Veterans Administration are not eligible for medical assistance covered case management services while they are receiving case management through the Veterans Administration. This payment limitation is applicable only if Veterans Administration reimbursed case management services are substantially similar to case management services covered by medical assistance.

4. Persons who are receiving relocation service coordination services under Supplement 1b to this Attachment are not eligible to receive the case management services described in this supplement for that month.

G. Payment: (continued)

5. Persons who are receiving case management services under Supplement 1c to this Attachment are not eligible to receive the case management services described in this supplement for that month.

6. Persons who are receiving assertive community treatment (ACT) services under item 13.d. to this Attachment are not eligible to receive the case management services described in this supplement for that month, except for the first and last months of ACT services.

7. The Department may suspend, reduce, or terminate the payment to a case management service provider that does not meet requirements, such as reporting. The county of responsibility, or, if applicable, the tribal agency, is responsible for any federal disallowances, but may share this responsibility with its contracted vendors.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: MINNESOTA

CHILD WELFARE - TARGETED CASE MANAGEMENT SERVICES

A. Target Group (section 1915(g) of the Act):

Child welfare-targeted case management services are available for recipients under age 21 who have been assessed in accordance with Minnesota Statutes, section 256F.10 and who meet one or more of the following conditions:

1. at risk of out-of-home placement or in out-of-home placement as defined in Minnesota Statutes, section 257.071, subdivision 1;

2. at risk of maltreatment or experiencing maltreatment, as defined in Minnesota Statutes, section 626.556, subdivision 10e; or

3. in need of protection or services as defined in Minnesota Statutes, section 260.015, subdivision 2a.

B. Areas of State in Which Services will be Provided:

_X_ Entire state.

___ Only in the following geographic areas (authority section 1915(g)(1) of the Act is invoked to provide services less than statewide):

C. Comparability of Services:

___ Services are provided in accordance with section 1902(a)(10) of the Act.

_X_ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

1. Child welfare-targeted case management services are those activities that assist eligible recipients in gaining access to needed medical, social, educational, and other services as identified in an individual service plan.

Child welfare-targeted case management services include the following activities:

a. assessment of the recipient's need for services to gain access to medical, social, educational, and other related services;

b. the development, completion, and regular review of a written individual service plan based on the assessment of need for case management services to ensure access to medical, social, educational, and other related services;

c. routine contact or other communication with the recipient, the recipient's family, primary caregiver, legal representative, substitute care provider, service providers, or other relevant persons identified as necessary to the development or implementation of the goals of the individual service plan in regard to the status of the recipient, the individual service plan, or goals for the recipient, exclusive of actual transportation of the recipient;

d. coordinating referrals for, and the provision of, child welfare-targeted case management services for the recipient with appropriate service providers, consistent with section 1902(a)(23) of the Act;

e. coordinating with the MA facility discharge planner in the 30-day period prior to the recipient's discharge into the community (this is the only child welfare-targeted case management service provided to patients or residents in a MA-funded facility and is limited to two months per calendar year);

f. coordinating and monitoring the overall service delivery to ensure quality of services;

D. Definition of Services: (continued)

g. monitoring and evaluating services on a regular basis to ensure appropriateness and continued need;

h. completing and maintaining necessary documentation that supports and verifies the above activities;

i. travel to conduct a visit with the recipient or other relevant person necessary to the development or implementation of the goals of the individual service plan; and

j. advocacy on behalf of the recipient through the provision of negotiating and coordinating activities for services that are otherwise inaccessible or unavailable to the client.

2. The following activities are not eligible for payment as child welfare-case targeted management services:

a. assessments prior to opening a case;

b. therapy and treatment services;

c. legal services, including legal advocacy, for the recipient;

d. information and referral services that are part of a county's or tribal social services' community social services plan and that are not related to an eligible recipient;

e. outreach services including outreach services provided through the community support services program;

f. services that are not documented as required under Minnesota Rules, parts 9505.2165 and 9505.2175 ~~to 9505.2195; 9505.0175 to 9505.0475; and 9505.5000 to 9505.5105~~;

g. services that are otherwise eligible for payment on a separate schedule under rules of the Department;

h. case management services that duplicate the same service from another case manager for the same recipient;

D. Definition of Services: (continued)

i. case management services provided to patients or residents in a MA reimbursed facility except as described under D.1.e.; and

j. case management services for children in foster care, group homes, or residential care that do not focus on permanency planning or return to the family home and/or duplicate the facility's discharge planning.

E. Qualifications of the Providers:

1. A child welfare-targeted case management provider must be an enrolled MA provider and possess all of the following capabilities:

a. demonstrated capacity to provide the components of child welfare-targeted case management;

b. demonstrated case management experience in coordinating and linking the community resources required by the target population;

c. administrative experience in serving the target population for whom he or she will provide services;

d. administrative capacity to ensure quality of services in accordance with state and federal requirements;

e. the ability to provide complete investigative, protective, foster care placement and related child welfare administrative services, or the ability to provide one or more of these activities through contract with the county or tribal social services;

f. a financial management system providing accurate documentation of services and costs; and

g. the capacity to document and maintain individual case records in accordance with state and federal requirements.

E. Qualifications of the Providers: (continued)

2. A case manager is an individual employed by and authorized by the child welfare-targeted case management provider to provide child welfare-targeted case management services. The case manager:

a. must be skilled in the process of identifying and assessing a wide range of children's needs;

b. must be knowledgeable about local community resources and how to use those resources for the benefit of the child; and

c. 1) must hold a bachelor's degree in social work, psychology, sociology, or a closely related field from an accredited four year college or university; or 2) hold a bachelor's degree in any field plus one year of supervised experience in the delivery of social services to children as a social worker in a public or private social services agency.

F. Freedom of Choice:

The State assures that the provision of child welfare-targeted case management services will not restrict a recipient's free choice of providers in violation of section 1902(a)(23) of the Act, except as provided for under section 1915(g)(1) of the Act.

1. Eligible recipients will have free choice of the providers of child welfare-targeted case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment:

Payment for child welfare-targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Services that are otherwise eligible for payment on a separate schedule under rules of the Department are not eligible for payment as child welfare-targeted case management services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: MINNESOTA
RELOCATION SERVICE COORDINATION SERVICES

A. **Target Group (section 1915(g) of the Act):**

Relocation service coordination services are provided to recipients residing in inpatient hospitals, nursing facilities, and intermediate care facilities for persons with ~~mental retardation~~ developmental disabilities (ICFs/~~MR~~DD) who choose to move from an institution to the community.

B. **Areas of the State in which services will be provided:**

X Entire state.

_ Only in the following geographic areas (authority section 1915 (g)(1) of the Act is invoked to provide services less than statewide).

C. **Comparability of services:**

X Services are provided in accordance with section 1902(a)(10)(B) of the Act.

_ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902 (a)(10)(B) of the Act.

D. **Definition of services:**

Relocation service coordination services are activities that are coordinated on an individual client basis and are designed to help recipients residing in institutions to gain access to needed

D. Definition of services: (continued)

medical, social, educational, financial, housing and other services and supports necessary to meet their needs in moving from an institution to the community.

Relocation service coordination services provided by a local social services agency; a federally recognized American Indian tribe; an entity under contract with a local social services agency or a federally recognized American Indian tribe; or a provider of mental health targeted case management under Supplement 1 include:

1. assessment of a recipient's need for medical, social, educational, financial, housing, and other services and supports;

2. development, completion, and regular review of a written individual service plan designed to help a recipient access medical, social, educational, financial, housing, and other related services and supports;

3. routine communication with the recipient and the recipient's: 1) family; 2) legal representative; 3) caregivers; 4) service providers; and 5) other relevant people identified as necessary to the development or implementation of the goals of the individual service plan;

4. coordinating referrals for, and the provision of, case management services for the recipient with appropriate service providers;

5. coordinating and monitoring the overall service delivery to ensure quality of services, appropriateness, and continued need;

6. completing and maintaining necessary documentation supporting and verifying relocation

D. Definition of services: (continued)

service coordination activities;

7. assisting recipients in order to access needed services, including travel to meet with the recipient or other relevant person necessary to develop or implement the goals of the individual service plan; and

8. coordinating with the institution discharge planner in the 180-day period before the recipient's discharge.

Relocation service coordination services provided by a private vendor include:

1. routine communication with the recipient and the recipient's: 1) family; 2) legal representative; 3) caregivers; 4) service providers; and 5) other relevant people identified as necessary to the development or implementation of the goals of the individual service plan;

2. coordinating and monitoring the overall service delivery to ensure quality of services, appropriateness, and continued need;

3. completing and maintaining necessary documentation supporting and verifying relocation service coordination activities;

4. assisting recipients in order to access needed services, including travel to meet with the recipient or other relevant person necessary to develop or implement the goals of the individual service plan; and

5. coordinating with the institution discharge planner in the 180-day period before the recipient's discharge.

The above components of relocation service coordination must fall with the following parameters to be eligible for medical assistance payment:

1. Payment for services is limited to the last 180 consecutive days before discharge.

2. Case management services will not duplicate those provided as part of the institution's discharge plan.

E. Qualifications of providers:

A provider of relocation service coordination services must be an enrolled medical assistance provider and:

1. a local social services agency;

2. a ~~facility of the~~ federally recognized American Indian ~~Health Service~~ tribe;

3. ~~a facility owned or operated by a tribe or tribal organization and funded by Title I of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, P.L. 106-260, operating as a 638 facility;~~

~~4.~~ an entity under contract with either the local social services agency~~,~~ or a ~~facility of the~~ federally recognized American Indian ~~Health Service, or a 638 facility~~ tribe; or

5. a private vendor.

Local social services agency case managers must ~~meet~~

E. Qualifications of providers: (continued)

~~the~~ ~~following standards~~ have:

1. a bachelor's degree or a license in a health or human services field, or comparable training and two years of experience in human services work;

2. demonstrated capacity and case management experience in providing the components of case management to coordinate and link community resources;

3. administrative capacity and case management experience in serving the target population for whom services will be provided;

4. administrative capacity to ensure quality of services in accordance with federal and state requirements;

5. a financial management system providing accurate documentation of services and costs;

6. capacity to document and maintain individual case records in accordance with federal and state requirements; and

~~7. except for private vendors, legal authority to provide complete investigative, protective, foster care placement and related child welfare administrative services, or the ability to provide one or more of these activities through contract with the county or tribal social services.~~

At a minimum, a case manager (other than a local social services agency case manager) must have:

1. a bachelor's degree or a license in a health

or human services field; or comparable training and two years of experience in human services work; or been credentialed as a health professional under standards set by the governing body of a federally recognized Indian tribe and who provides services to recipients through an Indian Health Service or 638 facility;

2. met the same standards listed, above, in items 2-6 that apply to local social services agency case managers;

3. the capacity to coordinate with county administrative functions; and

4. no financial interest in the provision of out-of-home residential services to recipients of relocation service coordination services. For purposes of this item, "out-of-home residential services" means services provided out of a recipient's familial home, such as foster care and boarding care home services.

A provider of mental health targeted case management under Supplement 1 may provide relocation service coordination services.

F. Freedom of choice:

The State assures that the provision of relocation service coordination services will not restrict a recipient's freedom of choice of provider in violation of section 1902(a)(23) of the Act.

1. An eligible recipient will have free choice of the providers of targeted case management services.

2. An eligible recipient will have free choice of the providers of other medical care under the

F. Freedom of choice (continued)

State plan.

G. Payment:

Payment for relocation service coordination management services under the State plan does not duplicate payment
made to public agencies or private entities under other program authorities for this same purpose.

1. Medicaid services that are otherwise eligible for payment on a separate schedule under rules of the Department are not eligible for payment as case management services.

2. Persons receiving mental health targeted case management services under Supplement 1 are not eligible to receive the case management services described in this supplement for that month.

3. Persons receiving case management services under Supplement 1c are not eligible to receive the case management services described in this supplement for that month.

4. Persons who are receiving assertive community treatment (ACT) services under item 13.d. to this Attachment are not eligible to receive the case management services described in this supplement for that month, except for the first and last months of ACT services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: MINNESOTA

TARGETED CASE MANAGEMENT SERVICES FOR PERSONS NOT RECEIVING SERVICES PURSUANT TO A §1915(c) WAIVER WHO ARE VULNERABLE ADULTS, ADULTS WITH ~~MENTAL RETARDATION~~ DEVELOPMENTAL DISABILITIES OR RELATED CONDITIONS, OR ADULTS WITHOUT A PERMANENT RESIDENCE

A. **Target Group (section 1915 (g) of the Act):**
Targeted case management services are provided to a recipient who is at least 18 years of age, who has significant functional impairments, who does not receive services pursuant to a § 1915(c) waiver who is:

1. In need of service coordination to attain or maintain living an integrated community setting; and

2. A vulnerable adult in need of adult protection, defined as an individual with a physical, mental or emotional disability:
   (a) that impairs the recipient's ability to provide adequately for the recipient's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and
   (b) because of the disability and the need for assistance, the recipient has an impaired ability to protect himself or herself from maltreatment;

3. An adult with ~~mental retardation~~ developmental disabilities or a related condition; or

4. An adult who has not had a permanent residence for at least one year or on at least four occasions in the last three years.

Additional limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service.

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements.

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act.

A. **Areas of the State in which services will be provided:**

X Entire state.

_ Only in the following geographic areas (authority section 1915{g) (1) of the Act is invoked to provide services less than statewide).

B. **Comparability of services:**

~~X~~ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration, and scope.

Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

C. **Definition of services:**

Targeted case management services are activities that are coordinated on an individual recipient basis and are designed to help recipients to gain access to needed medical, social and recreational, educational, vocational, advocacy, legal, and other services necessary to meet the recipient's needs. It does not include therapy, treatment, legal, or outreach services.

Targeted case management services include:

1. Comprehensive ~~A~~assessment and periodic reassessment of a recipient's need for targeted case management services plus any medical, educational, social or other services. These assessment activities include taking client history; identifying the individual's needs and completing related documentation; and gathering information from other sources such as family members, medical providers, and educators, to form a complete assessment of the individual.

2. Development, completion, and regular review and revision of a written individual service plan with the recipient and the recipient's legal representative, and others identified by the recipient, designed to help a recipient to gain access to needed medical, social and recreational, educational, vocational, advocacy, legal and other related services. The plan must be reviewed at least annually with the recipient and the recipient's legal representative. The plan must be revised when there is a change in the recipient's status.

D. **Definition of services:** (continued)

3. Routine communication with the recipient and the recipient's family, legal representative, caregivers, service providers, and other relevant people identified as necessary to the development or implementation of the goals of the individual service plan.

4. Coordinating referrals for, and the provision of, targeted case management services for the recipient with appropriate service providers.

5. Coordinating and monitoring the overall service delivery to ensure quality of services, appropriateness, effectiveness, and continued need.

6. Assistance to the recipient and the recipient's legal representative to help make an informed choice of services.

7. Advocating on behalf of the recipient when service barriers are encountered, or referring the recipient and the recipient's legal representative to an independent advocate.

8. Meeting face-to-face or by interactive video that meets the requirement in state statute with the recipient at least twice a year ~~which may occur via telephone, interactive video, or in person~~.

9. Completing and maintaining necessary documentation supporting and verifying targeted case management activities.

10. If a recipient is a resident or inpatient of an inpatient hospital, nursing facility, or intermediate care facility for persons with intellectual disabilities (ICF/DD), coordinating with the facility discharge planner in the 180-day period before the recipient's discharge. Institutions for mental diseases (IMDs) are not included in this facility list.

The above components of targeted case management services must fall within the following parameters to be eligible for medical assistance payment:

D. **Definition of services:** (continued)

1. ~~If a recipient is a resident or inpatient of an inpatient hospital, nursing facility, or ICF/MRID, payment for services is limited to the last 180 consecutive days before discharge~~ Target group includes individuals transition to a community setting. Case management services will be made available for 180 consecutive days of a covered stay in a medical institution.

2. Case management services will not duplicate those provided as part of the facility's discharge plan.

3. Case management services are not provided to individuals who are inmates of public institutions, or to individuals between the ages of 22 and 64 who are residing in an IMD.

E. **Qualifications of providers**:

A provider of targeted case management services must be an enrolled medical assistance provider and:

1. a local social services agency; or

2. an entity under contract with the local social services agency.

Case managers must meet the following standards:

1. Demonstrated capacity and case management experience in providing case management services to coordinate and link community resources.

2. Administrative capacity and case management experience in serving the target population for whom it will provide services.

3. Administrative capacity to ensure quality of services in accordance with federal and state requirements.

4. A financial management system providing accurate documentation of services and costs under federal and state requirements.

5. Capacity to document and maintain individual case records in accordance with federal and state requirements.

6. Coordinate with local social services agencies responsible for planning for community social services, conducting adult protective investigations, and conducting prepetition screenings for commitments.

7. Coordinate with health care providers to ensure access to necessary health care services.

8. The designated case manager must have at least a bachelor's degree in social work, special education, psychology, nursing, human services, or other fields related to the education or treatment of persons with disabilities, and one year of experience in the education or treatment of persons with disabilities.

Except for screening and service planning development services, the county board may establish procedures permitting others than those identified in item 8 to assist in providing case management services under the supervision of a case manager who meets the qualifications in item 8.

F. Freedom of Choice

The provision of targeted case management services will not restrict a recipient’s freedom of choice of provider in violation of 1902(a)(23) of the Act.

1. An eligible recipient will have free choice of the providers of targeted case management services.
2. An eligible recipient will have free choice of the providers of other medical care under the state plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: MINNESOTA

HOME CARE TARGETED CASE MANAGEMENT SERVICES

A. Target Group (section 1915(g) of the Act):

Home care case management services are provided to recipients not receiving any other case management services, who are receiving personal care assistant services, private duty nursing services, or any of the following services provided by a home health agency:

-home health aide;
-skilled nursing;
-physical therapy;
-occupational therapy; or
-speech therapy.

B. Areas of the State in which services will be provided:

X Entire state.

___ Only in the following geographic areas (authority section 1915(g)(1) of the Act is invoked to provide services less than statewide):

C. Comparability of services:

___ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of services:

Home care case management services are activities that are coordinated on an individual client basis and are designed to help home care service recipients to gain access to needed medical, social, educational, financial, housing and other services and supports necessary to meet their needs so that they remain in the community.

D. Definition of services: (continued)

Home care case management services include:

1. assessment of a recipient's need for medical, social, educational, financial, housing, and other services and supports;

2. development, completion, and regular review of a written individual service plan designed to help a recipient access medical, social, educational, financial, housing, and other related services and supports;

3. routine communication with the recipient and the recipient's family; legal representative; caregivers; service providers; and other relevant people identified as necessary to the development or implementation of the goals of the individual service plan;

4. coordinating referrals for, and the provision of, case management services for the recipient with appropriate service providers;

5. coordinating and monitoring the overall service delivery to ensure quality of services, appropriateness, and continued need;

6. completing and maintaining necessary documentation supporting and verifying home care case management activities;

7. assisting recipients in order to access needed services, including travel to meet with the recipient or other relevant person necessary to develop or implement the goals of the individual service plan; and

8. Meeting face-to-face with the recipient at least twice a year.

E. Qualifications of providers:

A provider of home care case management is:

1. a local social services agency;

2. a federally recognized American Indian tribe;

E. Qualifications of providers: (continued)

3. an entity under contract with either the local social services agency or a federally recognized American Indian tribe; or

4. a private entity.

A case manager of a local social services agency must have:

1. a bachelor's degree or a license in a health or human services field, or comparable training and two years of experience in human services work;

2. demonstrated capacity and case management experience in providing the components of case management to coordinate and link community resources;

3. administrative capacity and case management experience in serving the target population for whom services will be provided;

4. administrative capacity to ensure quality of services in accordance with federal and state requirements;

5. a financial management system providing accurate documentation of services and costs; and

6. capacity to document and maintain individual case records in accordance with federal and state requirements.

At a minimum, a case manager (other than a local social services agency case manager) must have:

1. a bachelor's degree or a license in a health or human services field; or comparable training and two years of experience in human services work; or, if providing services to recipients through an Indian Health Service or 638 facility, been credentialed as a health professional under standards set by the governing body of a federally recognized American Indian tribe;

2. met the same standards listed, above, in items 2-6 that apply to local social services agency case managers;

E. Qualifications of providers: (continued)

3. the capacity to coordinate with county administrative functions; and

4. no financial interest in the provision of out-of-home residential services to recipients of home care case management. For purposes of this item, "out-of-home residential services" means services provided out of a recipient's familial home, such as foster care and boarding care home services.

F. Freedom of choice:

The State assures that the provision of home care case management services will not restrict a recipient's freedom of choice of provider in violation of section 1902(a)(23) of the Act.

1. An eligible recipient will have free choice of the providers of case management services.

2. An eligible recipient will have free choice of the providers of other medical care under the State plan.

G. Payment:

- Payment for home care case management services under the State plan does not duplicate payment made to public agencies or private entities under other program authorities for this same purpose.

- Medicaid services that are otherwise eligible for payment on a separate schedule under rules of the Department are not eligible for payment as case management services.

- Persons receiving case management services under Supplements 1, 1a, 1b, or 1c to this Attachment are not eligible to receive the home care case management services described in this supplement for that month.

STATE: MINNESOTA
Effective: January 1, 1998
TN: 98-12
Approved: 5/13/98
Supersedes: 91-28

Supplement 2 to ATTACHMENT 3.1-A

HOME AND COMMUNITY CARE FOR FUNCTIONALLY DISABLED ELDERLY INDIVIDUALS

Home and community care for functionally disabled elderly individuals is not provided.

CONDITIONS FOR MEDICAL ASSISTANCE AND GENERAL ASSISTANCE MEDICAL CARE PAYMENT

9505.5000 APPLICABILITY.

Parts 9505.5000 to 9505.5105 establish the procedures for prior authorization of health services and the requirement of a second surgical opinion as conditions of payment to providers of health services for recipients of medical assistance, MinnesotaCare, and general assistance medical care.

These parts shall be read in conjunction with title XIX of the Social Security Act, Code of Federal Regulations, title 42, sections 430.00 to 489.57; Minnesota Statutes, sections 256.9353; 256B.01 to 256B.40; 256B.56 to 256B.71; 256D.01 to 256D.22; parts 9500.1070, subparts 1, 4, 6, 12 to 15, and 23; 9505.0170 to 9505.0475; 9505.0500 to 9505.0540; 9505.1000 to 9505.1040; and 9505.2160 to 9505.2245, and with rules adopted by the commissioner under Minnesota Statutes, sections 256.9352, 256.991, and 256D.03, subdivision 7, paragraph (b).

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03

HIST: 10 SR 842; 13 SR 1688; 19 SR 2433

9505.5005 DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 9505.5000 to 9505.5105 have the meanings given them in this part.

Subp. 1a. **Authorization number.** "Authorization number" means the number issued by:

A. the department, or an entity under contract to the department, to issue a number to a provider for the provision of a covered health service, as specified in part 9505.5010; or

B. the medical review agent that establishes that the surgical procedure requiring a second surgical opinion is medically appropriate.

Subp. 1b. **Certification number.** "Certification number" means the number issued by the medical review agent that establishes that all or part of a recipient's inpatient hospital services are medically necessary.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or an authorized designee.

Subp. 3. **Consultant.** "Consultant" means an individual who is licensed or registered according to state law or meets the credentials established by the respective professional organization in an area of health care or medical service; is employed by or under contract with the Department of Human Services; advises the department whether to approve, deny, or modify criteria for the approval of authorization requests in his or her area of expertise; advises the department on and recommends to the department policies concerning health services and whether health services meet the criteria in part 9505.5045; and performs other duties as assigned.

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

Subp. 5. **Emergency.** "Emergency" means a medical condition that, if not immediately diagnosed and treated, could cause a recipient serious physical or mental disability, continuation of severe pain, or death.

Subp. 6. **Fair hearing.** "Fair hearing" means an administrative proceeding under Minnesota Statutes, section 256.045 and as provided in part 9505.5105, to examine facts concerning the matter in dispute and to advise the commissioner whether the department's decision to reduce or deny benefits was correct.

Subp. 7. **General assistance medical care or GAMC.** "General assistance medical care" or "GAMC" means the health services provided to a recipient under the general assistance medical care program according to Minnesota Statutes, chapter 256D.

Subp. 8. **Health services.** "Health services" means the services and supplies furnished to a recipient by a provider as defined in subpart 16.

Subp. 9. **Investigative.** "Investigative" means:

A. A health service procedure which has progressed to limited human application and trial, which lacks wide recognition as a proven and effective procedure in clinical medicine as determined by the National Blue Cross and Blue Shield Association Medical Advisory Committee, and utilized by Blue Cross and Blue Shield of Minnesota in the administration of their program.

B. A drug or device that the United States Food and Drug Administration has not yet declared safe and effective for the use prescribed. For purposes of this definition, drugs and devices shall be those identified in the Food and Drug Act.

Subp. 10. **Local agency.** "Local agency" means a county or a multicounty agency that is authorized under Minnesota Statutes as the agency responsible for the administration of the medical assistance and general assistance medical care programs.

Subp. 11. **Local trade area.** "Local trade area" means the geographic area surrounding the recipient's residence which is commonly used by other persons in the same area to obtain necessary goods and services.

Subp. 12. **Medical assistance or MA.** "Medical assistance" or "MA" means the Medicaid program established by title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

Subp. 12a. **Medical appropriateness or medically appropriate.** "Medical appropriateness" or "medically appropriate" refers to a determination, by a medical review agent or the department, that the recipient's need for a surgical procedure requiring a second surgical opinion meets the criteria in part 9505.0540 or that a second or third surgical opinion has substantiated the need for the procedure.

Subp. 12b. **Medical review agent.** "Medical review agent" means the representative of the department who is authorized in parts 9505.0500 to 9505.0540 to determine the medical appropriateness of procedures requiring second surgical opinions.

Subp. 13. **Medicare.** "Medicare" means the health insurance program for the aged and disabled established by title XVIII of the Social Security Act.

Subp. 13a. **MinnesotaCare.** "MinnesotaCare" means the program established under Minnesota Statutes, sections 256.9351 to 256.9361.

Subp. 14. **Physician.** "Physician" means a person licensed to provide services within the scope of his or her profession as defined in Minnesota Statutes, chapter 147. For purposes of the second surgical opinion requirement in parts 9505.5035 to 9505.5100, "physician" shall also mean:

A. a person licensed to provide dental services within the scope of his or her profession as defined in Minnesota Statutes, section 150A.06, subdivision 1; or

B. a person who is qualified to render an opinion regarding the surgical procedure as evidenced by his or her certification or eligibility for certification from the appropriate specialty board if, according to the community standard, such certification or eligibility for certification is required of persons performing the surgical procedure in question.

Subp. 15. **Prior authorization.** "Prior authorization" means the written approval and issuance of an authorization number by the department, or by an entity under contract to the department, to a provider for the provision of a covered health service, as specified in part 9505.5010, prior to payment for that service.

Subp. 16. **Provider.** "Provider" means an individual or organization under an agreement with the department to furnish health services to persons eligible for the medical assistance, general assistance medical care, or MinnesotaCare programs.

Subp. 17. **Recipient.** "Recipient" means a person who is eligible for and receiving benefits from the medical assistance, general assistance medical care, or MinnesotaCare programs.

Subp. 18. **Referee.** "Referee" means an individual who conducts fair hearings under Minnesota Statutes, section 256.045 and recommends orders to the commissioner.

Subp. 18a. **Second opinion or second surgical opinion.** "Second opinion" or "second surgical opinion" means the determination by the medical review agent under part 9505.5050, subpart 1, or by a second physician under part 9505.5050, subpart 2, that a surgical procedure requiring a second surgical opinion is or is not medically appropriate.

Subp. 18b. **Third opinion or third surgical opinion.** "Third opinion" or "third surgical opinion" means the determination by a third physician under part 9505.5050, subpart 3, that a surgical procedure requiring a second surgical opinion is or is not medically appropriate.

Subp. 19. **Working days.** "Working days" means Monday through Friday, excluding state recognized legal holidays.

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03

HIST: 10 SR 842; 13 SR 1688; 19 SR 2433

9505.5010 PRIOR AUTHORIZATION REQUIREMENT.

Subpart 1. **Provider requirements.** A provider shall obtain prior authorization as a condition of payment under the medical assistance, general assistance medical care, and MinnesotaCare programs for health services designated under parts 9505.0170 to 9505.0475 and 9505.5025; and Minnesota Statutes, section 256B.0625, subdivision 25. The provider of the health service shall submit the request on form DHS-3065 or DHS-3066, or the American Dental Association (ADA) form as required in subpart 3, and shall submit materials, reports, progress notes, admission histories, and other information that substantiates that the service is medically necessary to treat the recipient. If the provider obtains prior authorization before the health service is provided but before payment, the provider shall be assured payment at the authorized level after the recipient has received the service. If a provider requests prior authorization after the service has been provided but before payment, the provider shall be assured of payment only if prior authorization is given. Additionally, prior authorization shall assure the provider payment for the approved health service only if the service is given during a time the person is a recipient and the provider meets all requirements of the medical assistance, general assistance medical care, or MinnesotaCare programs.

Subp. 2. **Repealed, 19 SR 2433**

Subp. 3. **Submission of forms.** The provider shall submit to the department a request for prior authorization on form DHS-3065 or DHS-3066, or the American Dental Association (ADA) form, which has been completed according to instructions in the Minnesota Health Care Programs Provider Manual, and other information necessary to address the criteria in part 9505.5030. The provider shall bear the burden of establishing compliance with the criteria in part 9505.5030 and shall submit information which demonstrates that the criteria in part 9505.5030 are met. The provider who administers or supervises the recipient's care shall personally review and sign the form and any attached documentation.

Subp. 4. **Consequences of failure to comply.** A provider who furnishes health services without obtaining prior authorization under parts 9505.5010 to 9505.5030 shall be denied payment. A physician, hospital, or other provider who is denied payment because of failure to comply with parts 9505.5010 to 9505.5030 shall not seek payment from the recipient and the recipient shall not be liable for payment of the service for which the provider is denied payment due to lack of prior authorization.

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03

HIST: 10 SR 842; 13 SR 1688; 16 SR 2102; 19 SR 2433

9505.5015 Repealed, 19 SR 2433

9505.5020 DEPARTMENT RESPONSIBILITIES.

Subpart 1. **Notification requirements.** If the information submitted by the provider does not meet the requirements of part 9505.5030, the department shall notify the provider of what is necessary to complete the request. The department shall send the provider, within 30 working days of receipt of all the information required in part 9505.5010, a notice of the action taken on the request for prior authorization. If the prior authorization request is denied, the department shall send the recipient within the same time period a copy of the notice sent to the provider and a statement of the recipient's right to appeal as provided in Minnesota Statutes, section 256.045.

Subp. 2. **Retention of information submitted by provider.** The department shall have the right to retain information submitted to the department by the provider in accordance with part 9505.5010.

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03
HIST: 10 SR 842; 19 SR 2433

9505.5025 HEALTH SERVICES PROVIDED OUTSIDE OF MINNESOTA.

Prior authorization for health services to be provided outside of Minnesota under part 9505.0215 must be obtained before the service is provided. A health service that is provided to a Minnesota resident outside of Minnesota but within the recipient's local trade area and that would not require prior authorization if it were provided to a Minnesota resident within Minnesota shall be exempt from the prior authorization requirement.

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03
HIST: 10 SR 842; 19 SR 2433

9505.5030 CRITERIA FOR APPROVAL OF PRIOR AUTHORIZATION REQUEST.

A request for prior authorization of a health service shall be evaluated by consultants using the criteria given in items A to F. A health service meeting the criteria in this part shall be approved, if the health service is otherwise a covered service under the MA or GAMC programs. The health service must:

A. be medically necessary as determined by prevailing medical community standards or customary practice and usage;

B. be appropriate and effective to the medical needs of the recipient;

C. be timely, considering the nature and present state of the recipient's medical condition;

D. be furnished by a provider with appropriate credentials;

E. be the least expensive appropriate alternative health service available; and

F. represent an effective and appropriate use of program funds.

STAT AUTH: MS s 256.991

HIST: 10 SR 842

9505.5035 SURGICAL PROCEDURES REQUIRING SECOND OPINION.

Subpart 1. **General requirements.** Except as provided in part 9505.5040, second surgical opinions shall be required for medical assistance and general assistance medical care recipients for inpatient and outpatient elective surgical procedures according to the list published in the State Register under Minnesota Statutes, section 256B.0625, subdivisions 1 and 4. Publication shall occur in the last issue of the State Register for the month of October if there has been a revision in the list since the last October. In addition, the department shall publish any revision of the list at least 45 days before the effective date if the revision imposes a second surgical opinion requirement. The department shall send each provider a copy of the published list or a revision of the published list.

Subp. 2. **Requirements prior to eligibility determination.** The requirements of parts 9505.5035 to 9505.5100 shall apply to individuals who have applied for MA or GAMC, but whose applications have not yet been approved or denied at the time the surgical procedure is performed.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; L 1988 c 689 art 2 s 268; 13 SR 1688

9505.5040 EXEMPTIONS TO SECOND SURGICAL OPINION REQUIREMENTS.

If the requirements of part 9505.5096 are met and the surgical procedure is medically appropriate as defined in part 9505.5005, subpart 12a, a second surgical opinion is not required in the circumstances set out in items A to F:

A. The surgical procedure is approved for reimbursement by Medicare.

B. The surgical procedure is a consequence of, or a customary and accepted practice as an incident to, a more major surgical procedure.

C. The procedure is an emergency. For an emergency, the physician shall submit substantiating documentation such as medical reports, progress notes, an admission history, or any other pertinent information necessary to substantiate the characterization of the surgical procedure as an emergency.

D. A visit to another physician to obtain a second opinion requires travel outside the local trade area.

E. The recipient has good cause for not obtaining a second opinion. Good cause refers to circumstances beyond the recipient's control. Examples of good cause include illness of the recipient, illness of a family member requiring the presence of the recipient, weather conditions that prohibit safe travel, or the unavailability of transportation.

F. The surgical procedure is performed before the individual's date of application for MA or GAMC, and retroactive eligibility was extended to cover the period of time during which the surgical procedure was performed.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; 13 SR 1688

9505.5045 CRITERIA TO DETERMINE WHEN SECOND OPINION IS REQUIRED.

The commissioner shall use the criteria in items A to E to determine which surgical procedures shall be subject to the second surgical opinion requirement.

A. Authoritative medical literature identifies the surgical procedure as being overutilized.

B. The surgical procedure is shown to be utilized to a greater degree within the Medicaid population than in the non-Medicaid population.

C. The utilization or cost of a surgical procedure falls within the top ten percent of all surgical procedures reimbursed under the MA and GAMC programs.

D. Alternative methods of treatment which are less intrusive are available.

E. The surgical procedure has at least a five percent rate of failure to obtain the requisite two physician's approvals, as determined by the Minnesota Medical Assistance Second Surgical Opinion Program or a similar second surgical opinion program.

STAT AUTH: MS s 256.991
HIST: 10 SR 842

9505.5050 SECOND AND THIRD SURGICAL OPINIONS.

Subpart 1. **Second surgical opinion by medical review agent.** Except as provided in subpart 2, a second surgical opinion must be obtained from the medical review agent as specified in parts 9505.0520, subparts 6 and 8, and 9505.0540.

Subp. 2. **Second surgical opinion by a second physician.** If the department does not have a contract with the medical review agent to provide a second surgical opinion, a second surgical opinion must be obtained from a second physician.

Subp. 3. **Third surgical opinion.** If a second surgical opinion obtained under subpart 1 or 2 fails to substantiate the initial surgical opinion and the recipient still wants the surgery, a third surgical opinion shall be obtained from a third physician. No opinion beyond the third opinion shall be considered in meeting the requirements of this part. The cost of an opinion beyond the third opinion shall not be reimbursed under the medical assistance or general assistance medical care program.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)
HIST: 10 SR 842; 13 SR 1688

9505.5055 SECOND OR THIRD OPINION BY A PHYSICIAN.

Subpart 1. **Duties of physician offering to provide the surgical service.** If the recipient requires the opinion of a second physician under part 9505.5050, subpart 2, or if the medical review agent or the second physician determines that the surgical procedure requiring a second surgical opinion is medically inappropriate and the recipient needs a third opinion

under part 9505.5050, subpart 3, the physician offering to provide the surgical service shall provide to the recipient in need of the second or third surgical opinion the names of at least two other physicians who are qualified to render the surgical opinion, or the name of an appropriate medical referral resource service, and information about the consequences of failing to obtain a second or third opinion. The physician offering the surgical service shall ensure that the required second opinion or third opinion is obtained.

Subp. 2. **Qualifications of physician offering second or third opinions.** The physician offering the surgical service and the physician named to render a second or third opinion or the medical referral resource service shall have no direct shared financial interest or referral relationship resulting in a shared financial gain. The physician who gives a second or third opinion must be a provider and must meet the criteria on experience in treating and diagnosing the condition that requires a second or third surgical opinion as published in the State Register under part 9505.5035.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)
HIST: 10 SR 842; 10 SR 1688

9505.5060 PENALTIES.

The penalties for failure to comply with parts 9505.5000 to 9505.5100 shall be imposed in accordance with parts 9505.2160 to 9505.2245 in addition to parts 9505.0145, 9505.0465, and 9505.0475.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)
HIST: 10 SR 842; 13 SR 1688

9505.5065 REIMBURSEMENT OF COST OF SECOND AND THIRD SURGICAL OPINIONS.

Reimbursement of the cost of a second or third surgical opinion under the medical assistance and general assistance medical care programs shall be permitted up to the allowable fee maximums as maintained by the department. When the physician who provides the second or third surgical opinion also performs the surgery, reimbursement for the surgery shall be denied.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)
HIST: 10 SR 842; 13 SR 1688

9505.5070 TIME LIMITS; SECOND AND THIRD OPINIONS; SURGERY.

The second surgical opinion from the medical review agent or a second physician shall be obtained within 90 days of the date of the initial opinion. The surgical opinion from a third physician, if required, shall be obtained within 45 days of the date of the opinion of the medical review agent or the second physician. Approved surgery, if not performed within 180 days of the initial opinion, and if still requested by the recipient, shall require repetition of the second surgical opinion process as described in this part.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; 13 SR 1688

9505.5075 PHYSICIAN RESPONSIBILITY.

The physician who provides a second or third opinion shall indicate his or her approval or disapproval of the requested surgical procedure, on a form supplied by the department. The completed form shall contain all the information considered necessary by the commissioner to substantiate the second opinion, shall be personally signed by each physician providing an opinion, and shall be attached to a completed and signed prior authorization form. The completed form must be returned to the physician offering to provide the surgical service and must be retained and made available, for at least five years, by the physician to the department as provided in part 9505.5080, or, on request, to a medical review agent under contract to the department.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)
HIST: 10 SR 842; 13 SR 1688

9505.5080 FAILURE TO OBTAIN REQUIRED OPINIONS.

Subpart 1. **Opinion of medical review agent.** Failure of the physician who offers to provide a surgical procedure requiring a second opinion to obtain a required surgical opinion from the medical review agent shall result in denial of reimbursement for all costs, direct and indirect, associated with the surgery, including costs attributable to other providers and hospitals.

Subp. 2. **Opinion of second or third physician.** Failure of a physician who offers to provide a surgical procedure requiring a second opinion to obtain the required surgical opinion from a second or third physician shall result in denial of reimbursement for all costs, direct and indirect, associated with the surgery, including costs attributable to other providers and hospitals except the providers who rendered the second or third surgical opinion.

Subp. 3. **Submission of completed form to department.** If the second or third opinion by a physician does not substantiate the need for the surgical procedure and if the department does not have a contract with a medical review agent, then the physician offering to provide the surgical procedure shall submit the completed form to the department within 135 days of the date of the first opinion. Failure to comply with this subpart may result in termination of the provider's agreement with the department.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)
HIST: 10 SR 842; 13 SR 1688

9505.5085 PROHIBITION OF PAYMENT REQUEST.

A physician, hospital, or other provider who is denied reimbursement because of failure to comply with parts 9505.5035 to 9505.5100 shall not seek payment from the recipient of the service, and the recipient shall not be liable for payment for

the service for which reimbursement was denied.

STAT AUTH: MS s 256.991

HIST: 10 SR 842

9505.5090 MEDICAL REVIEW AGENT AND DEPARTMENT RESPONSIBILITY.

Subpart 1. **Medical review agent responsibility.** Except as provided in subpart 2, if the medical review agent agrees that the requested surgical procedure is medically appropriate, the medical review agent shall certify that the requirements of this part are met, shall assign an authorization number within one working day of the medical review agent's receipt of the information, and shall issue a hospital admission certification number if the procedure requires inpatient hospital admission.

If the third physician, consulted according to part 9505.5050, subpart 3, agrees with the physician offering to provide the surgical service that the requested surgical procedure is medically appropriate, the medical review agent shall certify that the requirements of this part are met, shall assign an authorization number within one working day of the medical review agent's receipt of the necessary information and forms, and shall issue a hospital certification number.

If the third physician agrees with the second opinion provided by the medical review agent that the requested surgical procedure is not medically appropriate, then the medical review agent shall deny an authorization number and a certification number and the department shall deny authorization of reimbursement for the requested surgical procedure. The medical review agent shall send the recipient a copy of the notice denying authorization for the surgery and a statement of the recipient's right to appeal as provided in Minnesota Statutes, section 256.045.

Subp. 2. **If no medical review agent.** The department shall assign or deny an authorization number when the department does not have a contract with a medical review agent to determine the medical appropriateness of procedures requiring second surgical opinions.

If two of the three physicians agree that the requested surgical procedure is medically appropriate, the department shall certify that the requirements of this part are met and shall assign an authorization number within 30 working days of the department's receipt of the necessary information and forms.

If two of the three physicians agree that the requested surgical procedure is inappropriate, then the department shall deny authorization of reimbursement for the requested surgical procedure. The department shall send the recipient a copy of the notice denying authorization for the surgery and a statement of the recipient's right to appeal as provided in Minnesota Statutes, section 256.045.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; 13 SR 1688

9505.5095 **Repealed, 13 SR 1688**

9505.5096 REQUEST FOR EXEMPTION FROM SECOND SURGICAL OPINION.

Subpart 1. **Request for exemption; general.** A provider who believes a surgical procedure is exempt under part 9505.5040 from the second or third opinion requirement shall request approval of the exemption from the medical review agent or the department before carrying out the surgical procedure, except for exemptions under part 9505.5040, items B, C, and F, which may be requested after performing the surgical procedure.

Subp. 2. **Request for exemption before carrying out surgical procedure.** A provider shall request approval of the exemption either under item A or B.

A. If the department has a contract with a medical review agent, the provider shall call the medical review agent and provide the information required in parts 9505.5000 to 9505.5030.

B. If the department does not have a contract with a medical review agent, the provider shall submit the request to the department according to the prior authorization procedures in part 9505.5010.

Subp. 3. **Request for exemption after performing the surgical procedure.** If a provider chooses to carry out the surgical procedure before requesting approval of the exemption, the provider shall request approval of the exemption under item A or B.

A. If the department has a contract with a medical review agent, the provider shall submit to the medical review agent the medical records related to the recipient's medical condition, diagnosis, and treatment.

B. If the department does not have a contract with a medical review agent, the provider shall submit the request to the department according to the procedures in part 9505.5015.

Subp. 4. **Retroactive eligibility.** A hospital may seek an authorization number for a person found retroactively eligible for medical assistance or general assistance medical care program benefits after the date of admission. The hospital shall inform the physician offering to provide the surgical service of the authorization number of a retroactively eligible recipient. The physician offering to provide the surgical service and the hospital shall not seek an authorization number for a person whose application for the medical assistance or general assistance medical care program is pending. The medical review agent may require the hospital to submit, at its own expense, a copy of the complete medical record to substantiate the medical appropriateness of the surgical procedure. Failure to submit a requested record within 30 days of the request shall result in denial of the authorization number.

Subp. 5. **Documentation required.** A provider who believes a surgical procedure is exempt from the second and third opinion requirement under part 9505.5040 must submit supporting documentation with the request for exemption. If the provider requests approval of the exemption before performing the procedure, the department or medical review agent, as

appropriate, may withhold approval of the exemption until the provider has submitted the documentation.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 13 SR 1688

9505.5100 INDEPENDENT PHYSICIAN EVALUATION.

The commissioner shall have the right to order an independent evaluation by a physician selected by the recipient and approved by the commissioner when the commissioner has reason to believe, based on parts 9505.2160 to 9505.2245, that the requested surgical procedure is not medically appropriate. If the recipient needs assistance locating an appropriate physician, the services of the local county medical society, or any other physician referral resource may be used. If the selected physician determines the procedure is not medically appropriate, the commissioner shall deny authorization.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; 13 SR 1688

9505.5105 FAIR HEARINGS AND APPEALS.

Subpart 1. **Appealable actions.** A recipient may appeal any of the following department actions:

A. the department has failed to act with reasonable promptness on a request for prior authorization under parts 9505.5000 to 9505.5030 or on an authorization request under the second surgical opinion program, as established under part 9505.5090;

B. the department has denied a request for prior authorization under parts 9505.5000 to 9505.5030;

C. the department has denied an authorization request under the second surgical opinion program; or

D. the department has proposed a reduction in service as an alternative to authorization of a proposed service for which prior authorization under parts 9505.5000 to 9505.5030 was requested.

Subp. 2. **No right to appeal.** The right to appeal shall not apply to the list of surgical procedures established according to Minnesota Statutes, sections 256B.02, subdivision 8 and 256B.0625.

Subp. 3. **Request for fair hearing.** When a recipient requests assistance from a local agency in filing an appeal with the department, the local agency shall provide the assistance.

The request for a hearing must be submitted in writing by the recipient to the appeals unit of the department. The request must be filed either:

A. within 30 days of the date notice of denial of the request for prior authorization under parts 9505.5000 to 9505.5030 or request for authorization of a surgical procedure was received; or

B. no later than 90 days from the date notice of denial was received if the appeals referee finds there was good cause for the delay.

Subp. 4. **Fair hearing.** A referee shall conduct the hearing according to Minnesota Statutes, section 256.045, subdivision 4.

Subp. 5. **Commissioner's ruling.** Within 90 days of the date of receipt of the recipient's request for a hearing, the commissioner shall make a ruling to uphold, reverse, or modify the action or decision of the department or the medical review agent. The commissioner's ruling shall be binding upon the department and the recipient unless a request for judicial review is filed pursuant to Minnesota Statutes, section 256.045, subdivision 7.

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03

HIST: 10 SR 842; L 1988 c 689 art 2 s 268; 13 SR 1688; 19 SR 2433

STATE: MINNESOTA
Effective: July 1, 2005
TN: 05-03
Approved: MAY 18 2006
Supersedes: 96-08

Supplement 4 to Attachment 3.1-A

ALTERNATIVE HEALTH CARE PLANS

Minnesota enrolls recipients in ~~prepaid health plans~~ managed care organizations with which the State Medicaid agency contracts under the authority of §1903(m) and §1915(b) of the Act, and a §1115 waiver. Recipients are assured of access to services and of adequate quality through these contracts ~~which~~ that meet the requirements of 42 CFR §§434 and 438. The contracts require ~~prepaid health plans~~ managed care organizations to provide to enrollees the comprehensive health care services covered in Attachments 3.1-A and 3.1-B, except for the services listed in Attachment 3.1-F, item L, but ~~prepaid health plans~~ managed care organizations may also provide health care services in addition to the health care services in Attachments 3.1-A and 3.1-B when, in the judgment of the ~~prepaid health plans~~ managed care organizations, the provision of such services is medically necessary. The contracts also require the ~~prepaid health plans~~ managed care organizations to establish a quality assurance system under ~~42 CFR §434.34~~ 42 CFR §438, Subpart D.

STATE: MINNESOTA
Effective: January 1, 1998
TN: 98-12
Approved: 5/13/98
Supersedes: --

Supplement 5 to ATTACHMENT 3.1-A

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

PACE SERVICES

_x_ The State of Minnesota has not entered into any valid program agreements with a PACE provider and the Secretary of the Department of Health and Human Services.

___ The State of Minnesota has entered into a valid program agreement(s) with a PACE provider(s) and the Secretary, as follows:

Name of PACE provider: _____

Service area: _____

Maximum number of individuals to be enrolled: ____

Medical assistance covers medically necessary services and consultations delivered via telemedicine when performed by a licensed health care provider, or a mental health practitioner working under the supervision of a mental health professional, a certified community health worker, or a provider qualified in accordance with par. 13(d) of Attachment 3.1-A to provide a comprehensive assessment for substance use disorder services, in the same manner as if the service or consultation was delivered in person. Coverage is limited to three telemedicine services per enrollee per calendar week, except that this limit does not apply to services necessary for the treatment and control of tuberculosis that are provided by a licensed health care provider and in a manner consistent with the recommendations and best practices specified by the Centers for Disease Control and Prevention and the Commissioner of the Minnesota Department of Health.

Telemedicine is the delivery of health care services while the patient is at an originating site and the health care provider is at a distant site. A communication between health care providers, or a health care provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile does not constitute telemedicine services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing, or store-and-forward technology. Providers utilizing telemedicine must comply with criteria established by the Department in order to demonstrate that a quality assurance process and established protocols for patient safety have been addressed before, during, and after a particular service is delivered via telemedicine.

B. **Areas of the State in which services will be provided:**

X Entire state.

_ Only in the following geographic areas (authority section 1915{g) (1) of the Act is invoked to provide services less than statewide).

C. **Comparability of services:**

X Services are provided in accordance with section 1902(a)(10)(B) of the Act.

_ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. **Definition of services:**

Targeted case management services are activities that are coordinated on an individual recipient basis and are designed to help recipients to gain access to needed medical, social and recreational, educational, vocational, advocacy, legal, and other services necessary to meet the recipient's needs. It does not include therapy, treatment, legal, or outreach services.

Targeted case management services include:

1. Assessment of a recipient's need for targeted case management services.

2. Development, completion, and regular review and revision of a written individual service plan with the recipient and the recipient's legal representative, and others identified by the recipient, designed to help a recipient to gain access to needed medical, social and recreational, educational, vocational, advocacy, legal and other related services. The plan must be reviewed at least annually with the recipient and the recipient's legal representative. The plan must be revised when there is a change in the recipient's status.

D. **Definition of services:** (continued)

3. Routine communication with the recipient and the recipient's family, legal representative, caregivers, service providers, and other relevant people identified as necessary to the development or implementation of the goals of the individual service plan.

4. Coordinating referrals for, and the provision of, targeted case management services for the recipient with appropriate service providers.

5. Coordinating and monitoring the overall service delivery to ensure quality of services, appropriateness, effectiveness, and continued need.

6. Assistance to the recipient and the recipient's legal representative to help make an informed choice of services.

7. Advocating on behalf of the recipient when service barriers are encountered, or referring the recipient and the recipient's legal representative to an independent advocate.

8. Meeting face-to-face with the recipient at least twice a year. The use of interactive video may substitute for no more than 50 percent of the required face-to-face meetings.

9. Completing and maintaining necessary documentation supporting and verifying targeted case management activities.

10. If a recipient is a resident or inpatient of an inpatient hospital, nursing facility, or intermediate care facility for persons with ~~mental retardation~~ developmental disabilities (ICF/~~MR~~DD), coordinating with the facility discharge planner in the 180-day period before the recipient's discharge. Institutions for mental diseases (IMDs) are not included in this facility list.

The above components of targeted case management services must fall within the following parameters to be eligible for medical assistance payment:

D. **Definition of services:** (continued)

1. If a recipient is a resident or inpatient of an inpatient hospital, nursing facility, or ICF/~~MR~~DD, payment for services is limited to the last 180 consecutive days before discharge.

2. Case management services will not duplicate those provided as part of the facility's discharge plan.

E. **Qualifications of providers:**

A provider of targeted case management services must be an enrolled medical assistance provider and:

1. a local social services agency; or

2. an entity under contract with the local social services agency.

Case managers must meet the following standards:

1. Demonstrated capacity and case management experience in providing case management services to coordinate and link community resources.

2. Administrative capacity and case management experience in serving the target population for whom it will provide services.

3. Administrative capacity to ensure quality of services in accordance with federal and state requirements.

4. A financial management system providing accurate documentation of services and costs under federal and state requirements.

5. Capacity to document and maintain individual case records in accordance with federal and state requirements.

6. Coordinate with local social service agencies responsible for planning for community social services, conducting adult protective investigations, and conducting prepetition screenings for commitments.

E. Qualifications of providers: (continued)

7. Coordinate with health care providers to ensure access to necessary health care services.

F. Freedom of choice:

The State assures that the provision of targeted case management services will not restrict a recipient's freedom of choice of provider in violation of section 1902(a)(23) of the Act.

1. An eligible recipient will have free choice of the providers of targeted case management services.

2. An eligible recipient will have free choice of the providers of other medical care under the State plan.

G. Payment:

Payment for targeted case management services paid on a monthly basis under the State plan does not duplicate payment made to public agencies or private entities under other program authorities for this same purpose.

1. Medicaid services that are otherwise eligible for payment on a separate schedule under rules of the Department are not eligible for payment as case management services.

2. Persons receiving mental health targeted case management services under Supplement 1 are not eligible to receive the targeted case management services described in this supplement for that month.

3. Persons receiving relocation service coordination services under Supplement 1b are not eligible to receive the case management services described in this supplement for that month.

4. Persons who are receiving assertive community treatment (ACT) services under item 13.d. to this Attachment are not eligible to receive the case management services described in this supplement for that month, except for the first and last months of ACT services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: MINNESOTA

HOME CARE TARGETED CASE MANAGEMENT SERVICES

A. Target Group (section 1915(g) of the Act):

Home care case management services are provided to recipients not receiving any other case management services, who are receiving personal care assistant services, private duty nursing services, or any of the following services provided by a home health agency:

-home health aide;
-skilled nursing;
-physical therapy;
-occupational therapy; or
-speech therapy.

B. Areas of the State in which services will be provided:

X Entire state.

___ Only in the following geographic areas (authority section 1915(g)(1) of the Act is invoked to provide services less than statewide):

C. Comparability of services:

___ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of services:

Home care case management services are activities that are coordinated on an individual client basis and are designed to help home care service recipients to gain access to needed medical, social, educational, financial, housing and other services and supports necessary to meet their needs so that they remain in the community.

D. Definition of services: (continued)

Home care case management services include:

1. assessment of a recipient's need for medical, social, educational, financial, housing, and other services and supports;

2. development, completion, and regular review of a written individual service plan designed to help a recipient access medical, social, educational, financial, housing, and other related services and supports;

3. routine communication with the recipient and the recipient's family; legal representative; caregivers; service providers; and other relevant people identified as necessary to the development or implementation of the goals of the individual service plan;

4. coordinating referrals for, and the provision of, case management services for the recipient with appropriate service providers;

5. coordinating and monitoring the overall service delivery to ensure quality of services, appropriateness, and continued need;

6. completing and maintaining necessary documentation supporting and verifying home care case management activities;

7. assisting recipients in order to access needed services, including travel to meet with the recipient or other relevant person necessary to develop or implement the goals of the individual service plan; and

8. Meeting face-to-face with the recipient at least twice a year.

E. Qualifications of providers:

A provider of home care case management is:

1. a local social services agency;

2. a federally recognized American Indian tribe;

E. Qualifications of providers: (continued)

3. an entity under contract with either the local social services agency or a federally recognized American Indian tribe; or

4. a private entity.

A case manager of a local social services agency must have:

1. a bachelor's degree or a license in a health or human services field, or comparable training and two years of experience in human services work;

2. demonstrated capacity and case management experience in providing the components of case management to coordinate and link community resources;

3. administrative capacity and case management experience in serving the target population for whom services will be provided;

4. administrative capacity to ensure quality of services in accordance with federal and state requirements;

5. a financial management system providing accurate documentation of services and costs; and

6. capacity to document and maintain individual case records in accordance with federal and state requirements.

At a minimum, a case manager (other than a local social services agency case manager) must have:

1. a bachelor's degree or a license in a health or human services field; or comparable training and two years of experience in human services work; or, if providing services to recipients through an Indian Health Service or 638 facility, been credentialed as a health professional under standards set by the governing body of a federally recognized American Indian tribe;

2. met the same standards listed, above, in items 2-6 that apply to local social services agency case managers;

E. Qualifications of providers: (continued)

3. the capacity to coordinate with county administrative functions; and

4. no financial interest in the provision of out-of-home residential services to recipients of home care case management. For purposes of this item, "out-of-home residential services" means services provided out of a recipient's familial home, such as foster care and boarding care home services.

F. Freedom of choice:

The State assures that the provision of home care case management services will not restrict a recipient's freedom of choice of provider in violation of section 1902(a)(23) of the Act.

1. An eligible recipient will have free choice of the providers of case management services.

2. An eligible recipient will have free choice of the providers of other medical care under the State plan.

G. Payment:

- Payment for home care case management services under the State plan does not duplicate payment made to public agencies or private entities under other program authorities for this same purpose.

- Medicaid services that are otherwise eligible for payment on a separate schedule under rules of the Department are not eligible for payment as case management services.

- Persons receiving case management services under Supplements 1, 1a, 1b, or 1c to this Attachment are not eligible to receive the home care case management services described in this supplement for that month.

STATE: MINNESOTA
Effective: January 1, 1998
TN: 98-12
Approved: 5/13/98
Supersedes: 91-28

Supplement 2 to ATTACHMENT 3.1-A

HOME AND COMMUNITY CARE FOR FUNCTIONALLY DISABLED ELDERLY INDIVIDUALS

Home and community care for functionally disabled elderly individuals is not provided.

CONDITIONS FOR MEDICAL ASSISTANCE AND GENERAL ASSISTANCE MEDICAL CARE PAYMENT

9505.5000 APPLICABILITY.

Parts 9505.5000 to 9505.5105 establish the procedures for prior authorization of health services and the requirement of a second surgical opinion as conditions of payment to providers of health services for recipients of medical assistance, MinnesotaCare, and general assistance medical care.

These parts shall be read in conjunction with title XIX of the Social Security Act, Code of Federal Regulations, title 42, sections 430.00 to 489.57; Minnesota Statutes, sections 256.9353; 256B.01 to 256B.40; 256B.56 to 256B.71; 256D.01 to 256D.22; parts 9500.1070, subparts 1, 4, 6, 12 to 15, and 23; 9505.0170 to 9505.0475; 9505.0500 to 9505.0540; 9505.1000 to 9505.1040; and 9505.2160 to 9505.2245, and with rules adopted by the commissioner under Minnesota Statutes, sections 256.9352, 256.991, and 256D.03, subdivision 7, paragraph (b).

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03

HIST: 10 SR 842; 13 SR 1688; 19 SR 2433

9505.5005 DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 9505.5000 to 9505.5105 have the meanings given them in this part.

Subp. 1a. **Authorization number.** "Authorization number" means the number issued by:

A. the department, or an entity under contract to the department, to issue a number to a provider for the provision of a covered health service, as specified in part 9505.5010; or

B. the medical review agent that establishes that the surgical procedure requiring a second surgical opinion is medically appropriate.

Subp. 1b. **Certification number.** "Certification number" means the number issued by the medical review agent that establishes that all or part of a recipient's inpatient hospital services are medically necessary.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or an authorized designee.

Subp. 3. **Consultant.** "Consultant" means an individual who is licensed or registered according to state law or meets the credentials established by the respective professional organization in an area of health care or medical service; is employed by or under contract with the Department of Human Services; advises the department whether to approve, deny, or modify criteria for the approval of authorization requests in his or her area of expertise; advises the department on and recommends to the department policies concerning health services and whether health services meet the criteria in part 9505.5045; and performs other duties as assigned.

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

Subp. 5. **Emergency.** "Emergency" means a medical condition that, if not immediately diagnosed and treated, could cause a recipient serious physical or mental disability, continuation of severe pain, or death.

Subp. 6. **Fair hearing.** "Fair hearing" means an administrative proceeding under Minnesota Statutes, section 256.045 and as provided in part 9505.5105, to examine facts concerning the matter in dispute and to advise the commissioner whether the department's decision to reduce or deny benefits was correct.

Subp. 7. **General assistance medical care or GAMC.** "General assistance medical care" or "GAMC" means the health services provided to a recipient under the general assistance medical care program according to Minnesota Statutes, chapter 256D.

Subp. 8. **Health services.** "Health services" means the services and supplies furnished to a recipient by a provider as defined in subpart 16.

Subp. 9. **Investigative.** "Investigative" means:

A. A health service procedure which has progressed to limited human application and trial, which lacks wide recognition as a proven and effective procedure in clinical medicine as determined by the National Blue Cross and Blue Shield Association Medical Advisory Committee, and utilized by Blue Cross and Blue Shield of Minnesota in the administration of their program.

B. A drug or device that the United States Food and Drug Administration has not yet declared safe and effective for the use prescribed. For purposes of this definition, drugs and devices shall be those identified in the Food and Drug Act.

Subp. 10. **Local agency.** "Local agency" means a county or a multicounty agency that is authorized under Minnesota Statutes as the agency responsible for the administration of the medical assistance and general assistance medical care programs.

Subp. 11. **Local trade area.** "Local trade area" means the geographic area surrounding the recipient's residence which is commonly used by other persons in the same area to obtain necessary goods and services.

Subp. 12. **Medical assistance or MA.** "Medical assistance" or "MA" means the Medicaid program established by title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

Subp. 12a. **Medical appropriateness or medically appropriate.** "Medical appropriateness" or "medically appropriate" refers to a determination, by a medical review agent or the department, that the recipient's need for a surgical procedure requiring a second surgical opinion meets the criteria in part 9505.0540 or that a second or third surgical opinion has substantiated the need for the procedure.

Subp. 12b. **Medical review agent.** "Medical review agent" means the representative of the department who is authorized in parts 9505.0500 to 9505.0540 to determine the medical appropriateness of procedures requiring second surgical opinions.

Subp. 13. **Medicare.** "Medicare" means the health insurance program for the aged and disabled established by title XVIII of the Social Security Act.

Subp. 13a. **MinnesotaCare.** "MinnesotaCare" means the program established under Minnesota Statutes, sections 256.9351 to 256.9361.

Subp. 14. **Physician.** "Physician" means a person licensed to provide services within the scope of his or her profession as defined in Minnesota Statutes, chapter 147. For purposes of the second surgical opinion requirement in parts 9505.5035 to 9505.5100, "physician" shall also mean:

A. a person licensed to provide dental services within the scope of his or her profession as defined in Minnesota Statutes, section 150A.06, subdivision 1; or

B. a person who is qualified to render an opinion regarding the surgical procedure as evidenced by his or her certification or eligibility for certification from the appropriate specialty board if, according to the community standard, such certification or eligibility for certification is required of persons performing the surgical procedure in question.

Subp. 15. **Prior authorization.** "Prior authorization" means the written approval and issuance of an authorization number by the department, or by an entity under contract to the department, to a provider for the provision of a covered health service, as specified in part 9505.5010, prior to payment for that service.

Subp. 16. **Provider.** "Provider" means an individual or organization under an agreement with the department to furnish health services to persons eligible for the medical assistance, general assistance medical care, or MinnesotaCare programs.

Subp. 17. **Recipient.** "Recipient" means a person who is eligible for and receiving benefits from the medical assistance, general assistance medical care, or MinnesotaCare programs.

Subp. 18. **Referee.** "Referee" means an individual who conducts fair hearings under Minnesota Statutes, section 256.045 and recommends orders to the commissioner.

Subp. 18a. **Second opinion or second surgical opinion.** "Second opinion" or "second surgical opinion" means the determination by the medical review agent under part 9505.5050, subpart 1, or by a second physician under part 9505.5050, subpart 2, that a surgical procedure requiring a second surgical opinion is or is not medically appropriate.

Subp. 18b. **Third opinion or third surgical opinion.** "Third opinion" or "third surgical opinion" means the determination by a third physician under part 9505.5050, subpart 3, that a surgical procedure requiring a second surgical opinion is or is not medically appropriate.

Subp. 19. **Working days.** "Working days" means Monday through Friday, excluding state recognized legal holidays.

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03

HIST: 10 SR 842; 13 SR 1688; 19 SR 2433

9505.5010 PRIOR AUTHORIZATION REQUIREMENT.

Subpart 1. **Provider requirements.** A provider shall obtain prior authorization as a condition of payment under the medical assistance, general assistance medical care, and MinnesotaCare programs for health services designated under parts 9505.0170 to 9505.0475 and 9505.5025; and Minnesota Statutes, section 256B.0625, subdivision 25. The provider of the health service shall submit the request on form DHS-3065 or DHS-3066, or the American Dental Association (ADA) form as required in subpart 3, and shall submit materials, reports, progress notes, admission histories, and other information that substantiates that the service is medically necessary to treat the recipient. If the provider obtains prior authorization before the health service is provided but before payment, the provider shall be assured payment at the authorized level after the recipient has received the service. If a provider requests prior authorization after the service has been provided but before payment, the provider shall be assured of payment only if prior authorization is given. Additionally, prior authorization shall assure the provider payment for the approved health service only if the service is given during a time the person is a recipient and the provider meets all requirements of the medical assistance, general assistance medical care, or MinnesotaCare programs.

Subp. 2. **Repealed, 19 SR 2433**

Subp. 3. **Submission of forms.** The provider shall submit to the department a request for prior authorization on form DHS-3065 or DHS-3066, or the American Dental Association (ADA) form, which has been completed according to instructions in the Minnesota Health Care Programs Provider Manual, and other information necessary to address the criteria in part 9505.5030. The provider shall bear the burden of establishing compliance with the criteria in part 9505.5030 and shall submit information which demonstrates that the criteria in part 9505.5030 are met. The provider who administers or supervises the recipient's care shall personally review and sign the form and any attached documentation.

Subp. 4. **Consequences of failure to comply.** A provider who furnishes health services without obtaining prior authorization under parts 9505.5010 to 9505.5030 shall be denied payment. A physician, hospital, or other provider who is denied payment because of failure to comply with parts 9505.5010 to 9505.5030 shall not seek payment from the recipient and the recipient shall not be liable for payment of the service for which the provider is denied payment due to lack of prior authorization.

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03

HIST: 10 SR 842; 13 SR 1688; 16 SR 2102; 19 SR 2433

9505.5015 Repealed, 19 SR 2433

9505.5020 DEPARTMENT RESPONSIBILITIES.

Subpart 1. **Notification requirements.** If the information submitted by the provider does not meet the requirements of part 9505.5030, the department shall notify the provider of what is necessary to complete the request. The department shall send the provider, within 30 working days of receipt of all the information required in part 9505.5010, a notice of the action taken on the request for prior authorization. If the prior authorization request is denied, the department shall send the recipient within the same time period a copy of the notice sent to the provider and a statement of the recipient's right to appeal as provided in Minnesota Statutes, section 256.045.

Subp. 2. **Retention of information submitted by provider.** The department shall have the right to retain information submitted to the department by the provider in accordance with part 9505.5010.

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03
HIST: 10 SR 842; 19 SR 2433

9505.5025 HEALTH SERVICES PROVIDED OUTSIDE OF MINNESOTA.

Prior authorization for health services to be provided outside of Minnesota under part 9505.0215 must be obtained before the service is provided. A health service that is provided to a Minnesota resident outside of Minnesota but within the recipient's local trade area and that would not require prior authorization if it were provided to a Minnesota resident within Minnesota shall be exempt from the prior authorization requirement.

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03
HIST: 10 SR 842; 19 SR 2433

9505.5030 CRITERIA FOR APPROVAL OF PRIOR AUTHORIZATION REQUEST.

A request for prior authorization of a health service shall be evaluated by consultants using the criteria given in items A to F. A health service meeting the criteria in this part shall be approved, if the health service is otherwise a covered service under the MA or GAMC programs. The health service must:

A. be medically necessary as determined by prevailing medical community standards or customary practice and usage;

B. be appropriate and effective to the medical needs of the recipient;

C. be timely, considering the nature and present state of the recipient's medical condition;

D. be furnished by a provider with appropriate credentials;

E. be the least expensive appropriate alternative health service available; and

F. represent an effective and appropriate use of program funds.

STAT AUTH: MS s 256.991

HIST: 10 SR 842

9505.5035 SURGICAL PROCEDURES REQUIRING SECOND OPINION.

Subpart 1. **General requirements.** Except as provided in part 9505.5040, second surgical opinions shall be required for medical assistance and general assistance medical care recipients for inpatient and outpatient elective surgical procedures according to the list published in the State Register under Minnesota Statutes, section 256B.0625, subdivisions 1 and 4. Publication shall occur in the last issue of the State Register for the month of October if there has been a revision in the list since the last October. In addition, the department shall publish any revision of the list at least 45 days before the effective date if the revision imposes a second surgical opinion requirement. The department shall send each provider a copy of the published list or a revision of the published list.

Subp. 2. **Requirements prior to eligibility determination.** The requirements of parts 9505.5035 to 9505.5100 shall apply to individuals who have applied for MA or GAMC, but whose applications have not yet been approved or denied at the time the surgical procedure is performed.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; L 1988 c 689 art 2 s 268; 13 SR 1688

9505.5040 EXEMPTIONS TO SECOND SURGICAL OPINION REQUIREMENTS.

If the requirements of part 9505.5096 are met and the surgical procedure is medically appropriate as defined in part 9505.5005, subpart 12a, a second surgical opinion is not required in the circumstances set out in items A to F:

A. The surgical procedure is approved for reimbursement by Medicare.

B. The surgical procedure is a consequence of, or a customary and accepted practice as an incident to, a more major surgical procedure.

C. The procedure is an emergency. For an emergency, the physician shall submit substantiating documentation such as medical reports, progress notes, an admission history, or any other pertinent information necessary to substantiate the characterization of the surgical procedure as an emergency.

D. A visit to another physician to obtain a second opinion requires travel outside the local trade area.

E. The recipient has good cause for not obtaining a second opinion. Good cause refers to circumstances beyond the recipient's control. Examples of good cause include illness of the recipient, illness of a family member requiring the presence of the recipient, weather conditions that prohibit safe travel, or the unavailability of transportation.

F. The surgical procedure is performed before the individual's date of application for MA or GAMC, and retroactive eligibility was extended to cover the period of time during which the surgical procedure was performed.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; 13 SR 1688

9505.5045 CRITERIA TO DETERMINE WHEN SECOND OPINION IS REQUIRED.

The commissioner shall use the criteria in items A to E to determine which surgical procedures shall be subject to the second surgical opinion requirement.

A. Authoritative medical literature identifies the surgical procedure as being overutilized.

B. The surgical procedure is shown to be utilized to a greater degree within the Medicaid population than in the non-Medicaid population.

C. The utilization or cost of a surgical procedure falls within the top ten percent of all surgical procedures reimbursed under the MA and GAMC programs.

D. Alternative methods of treatment which are less intrusive are available.

E. The surgical procedure has at least a five percent rate of failure to obtain the requisite two physician's approvals, as determined by the Minnesota Medical Assistance Second Surgical Opinion Program or a similar second surgical opinion program.

STAT AUTH: MS s 256.991
HIST: 10 SR 842

9505.5050 SECOND AND THIRD SURGICAL OPINIONS.

Subpart 1. **Second surgical opinion by medical review agent.** Except as provided in subpart 2, a second surgical opinion must be obtained from the medical review agent as specified in parts 9505.0520, subparts 6 and 8, and 9505.0540.

Subp. 2. **Second surgical opinion by a second physician.** If the department does not have a contract with the medical review agent to provide a second surgical opinion, a second surgical opinion must be obtained from a second physician.

Subp. 3. **Third surgical opinion.** If a second surgical opinion obtained under subpart 1 or 2 fails to substantiate the initial surgical opinion and the recipient still wants the surgery, a third surgical opinion shall be obtained from a third physician. No opinion beyond the third opinion shall be considered in meeting the requirements of this part. The cost of an opinion beyond the third opinion shall not be reimbursed under the medical assistance or general assistance medical care program.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)
HIST: 10 SR 842; 13 SR 1688

9505.5055 SECOND OR THIRD OPINION BY A PHYSICIAN.

Subpart 1. **Duties of physician offering to provide the surgical service.** If the recipient requires the opinion of a second physician under part 9505.5050, subpart 2, or if the medical review agent or the second physician determines that the surgical procedure requiring a second surgical opinion is medically inappropriate and the recipient needs a third opinion

under part 9505.5050, subpart 3, the physician offering to provide the surgical service shall provide to the recipient in need of the second or third surgical opinion the names of at least two other physicians who are qualified to render the surgical opinion, or the name of an appropriate medical referral resource service, and information about the consequences of failing to obtain a second or third opinion. The physician offering the surgical service shall ensure that the required second opinion or third opinion is obtained.

Subp. 2. **Qualifications of physician offering second or third opinions.** The physician offering the surgical service and the physician named to render a second or third opinion or the medical referral resource service shall have no direct shared financial interest or referral relationship resulting in a shared financial gain. The physician who gives a second or third opinion must be a provider and must meet the criteria on experience in treating and diagnosing the condition that requires a second or third surgical opinion as published in the State Register under part 9505.5035.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)
HIST: 10 SR 842; 10 SR 1688

9505.5060 PENALTIES.

The penalties for failure to comply with parts 9505.5000 to 9505.5100 shall be imposed in accordance with parts 9505.2160 to 9505.2245 in addition to parts 9505.0145, 9505.0465, and 9505.0475.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)
HIST: 10 SR 842; 13 SR 1688

9505.5065 REIMBURSEMENT OF COST OF SECOND AND THIRD SURGICAL OPINIONS.

Reimbursement of the cost of a second or third surgical opinion under the medical assistance and general assistance medical care programs shall be permitted up to the allowable fee maximums as maintained by the department. When the physician who provides the second or third surgical opinion also performs the surgery, reimbursement for the surgery shall be denied.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)
HIST: 10 SR 842; 13 SR 1688

9505.5070 TIME LIMITS; SECOND AND THIRD OPINIONS; SURGERY.

The second surgical opinion from the medical review agent or a second physician shall be obtained within 90 days of the date of the initial opinion. The surgical opinion from a third physician, if required, shall be obtained within 45 days of the date of the opinion of the medical review agent or the second physician. Approved surgery, if not performed within 180 days of the initial opinion, and if still requested by the recipient, shall require repetition of the second surgical opinion process as described in this part.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; 13 SR 1688

9505.5075 PHYSICIAN RESPONSIBILITY.

The physician who provides a second or third opinion shall indicate his or her approval or disapproval of the requested surgical procedure, on a form supplied by the department. The completed form shall contain all the information considered necessary by the commissioner to substantiate the second opinion, shall be personally signed by each physician providing an opinion, and shall be attached to a completed and signed prior authorization form. The completed form must be returned to the physician offering to provide the surgical service and must be retained and made available, for at least five years, by the physician to the department as provided in part 9505.5080, or, on request, to a medical review agent under contract to the department.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)
HIST: 10 SR 842; 13 SR 1688

9505.5080 FAILURE TO OBTAIN REQUIRED OPINIONS.

Subpart 1. **Opinion of medical review agent.** Failure of the physician who offers to provide a surgical procedure requiring a second opinion to obtain a required surgical opinion from the medical review agent shall result in denial of reimbursement for all costs, direct and indirect, associated with the surgery, including costs attributable to other providers and hospitals.

Subp. 2. **Opinion of second or third physician.** Failure of a physician who offers to provide a surgical procedure requiring a second opinion to obtain the required surgical opinion from a second or third physician shall result in denial of reimbursement for all costs, direct and indirect, associated with the surgery, including costs attributable to other providers and hospitals except the providers who rendered the second or third surgical opinion.

Subp. 3. **Submission of completed form to department.** If the second or third opinion by a physician does not substantiate the need for the surgical procedure and if the department does not have a contract with a medical review agent, then the physician offering to provide the surgical procedure shall submit the completed form to the department within 135 days of the date of the first opinion. Failure to comply with this subpart may result in termination of the provider's agreement with the department.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)
HIST: 10 SR 842; 13 SR 1688

9505.5085 PROHIBITION OF PAYMENT REQUEST.

A physician, hospital, or other provider who is denied reimbursement because of failure to comply with parts 9505.5035 to 9505.5100 shall not seek payment from the recipient of the service, and the recipient shall not be liable for payment for

the service for which reimbursement was denied.

STAT AUTH: MS s 256.991

HIST: 10 SR 842

9505.5090 MEDICAL REVIEW AGENT AND DEPARTMENT RESPONSIBILITY.

Subpart 1. **Medical review agent responsibility.** Except as provided in subpart 2, if the medical review agent agrees that the requested surgical procedure is medically appropriate, the medical review agent shall certify that the requirements of this part are met, shall assign an authorization number within one working day of the medical review agent's receipt of the information, and shall issue a hospital admission certification number if the procedure requires inpatient hospital admission.

If the third physician, consulted according to part 9505.5050, subpart 3, agrees with the physician offering to provide the surgical service that the requested surgical procedure is medically appropriate, the medical review agent shall certify that the requirements of this part are met, shall assign an authorization number within one working day of the medical review agent's receipt of the necessary information and forms, and shall issue a hospital certification number.

If the third physician agrees with the second opinion provided by the medical review agent that the requested surgical procedure is not medically appropriate, then the medical review agent shall deny an authorization number and a certification number and the department shall deny authorization of reimbursement for the requested surgical procedure. The medical review agent shall send the recipient a copy of the notice denying authorization for the surgery and a statement of the recipient's right to appeal as provided in Minnesota Statutes, section 256.045.

Subp. 2. **If no medical review agent.** The department shall assign or deny an authorization number when the department does not have a contract with a medical review agent to determine the medical appropriateness of procedures requiring second surgical opinions.

If two of the three physicians agree that the requested surgical procedure is medically appropriate, the department shall certify that the requirements of this part are met and shall assign an authorization number within 30 working days of the department's receipt of the necessary information and forms.

If two of the three physicians agree that the requested surgical procedure is inappropriate, then the department shall deny authorization of reimbursement for the requested surgical procedure. The department shall send the recipient a copy of the notice denying authorization for the surgery and a statement of the recipient's right to appeal as provided in Minnesota Statutes, section 256.045.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; 13 SR 1688

9505.5095 **Repealed, 13 SR 1688**

9505.5096 REQUEST FOR EXEMPTION FROM SECOND SURGICAL OPINION.

Subpart 1. **Request for exemption; general.** A provider who believes a surgical procedure is exempt under part 9505.5040 from the second or third opinion requirement shall request approval of the exemption from the medical review agent or the department before carrying out the surgical procedure, except for exemptions under part 9505.5040, items B, C, and F, which may be requested after performing the surgical procedure.

Subp. 2. **Request for exemption before carrying out surgical procedure.** A provider shall request approval of the exemption either under item A or B.

A. If the department has a contract with a medical review agent, the provider shall call the medical review agent and provide the information required in parts 9505.5000 to 9505.5030.

B. If the department does not have a contract with a medical review agent, the provider shall submit the request to the department according to the prior authorization procedures in part 9505.5010.

Subp. 3. **Request for exemption after performing the surgical procedure.** If a provider chooses to carry out the surgical procedure before requesting approval of the exemption, the provider shall request approval of the exemption under item A or B.

A. If the department has a contract with a medical review agent, the provider shall submit to the medical review agent the medical records related to the recipient's medical condition, diagnosis, and treatment.

B. If the department does not have a contract with a medical review agent, the provider shall submit the request to the department according to the procedures in part 9505.5015.

Subp. 4. **Retroactive eligibility.** A hospital may seek an authorization number for a person found retroactively eligible for medical assistance or general assistance medical care program benefits after the date of admission. The hospital shall inform the physician offering to provide the surgical service of the authorization number of a retroactively eligible recipient. The physician offering to provide the surgical service and the hospital shall not seek an authorization number for a person whose application for the medical assistance or general assistance medical care program is pending. The medical review agent may require the hospital to submit, at its own expense, a copy of the complete medical record to substantiate the medical appropriateness of the surgical procedure. Failure to submit a requested record within 30 days of the request shall result in denial of the authorization number.

Subp. 5. **Documentation required.** A provider who believes a surgical procedure is exempt from the second and third opinion requirement under part 9505.5040 must submit supporting documentation with the request for exemption. If the provider requests approval of the exemption before performing the procedure, the department or medical review agent, as

appropriate, may withhold approval of the exemption until the provider has submitted the documentation.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 13 SR 1688

9505.5100 INDEPENDENT PHYSICIAN EVALUATION.

The commissioner shall have the right to order an independent evaluation by a physician selected by the recipient and approved by the commissioner when the commissioner has reason to believe, based on parts 9505.2160 to 9505.2245, that the requested surgical procedure is not medically appropriate. If the recipient needs assistance locating an appropriate physician, the services of the local county medical society, or any other physician referral resource may be used. If the selected physician determines the procedure is not medically appropriate, the commissioner shall deny authorization.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; 13 SR 1688

9505.5105 FAIR HEARINGS AND APPEALS.

Subpart 1. **Appealable actions.** A recipient may appeal any of the following department actions:

A. the department has failed to act with reasonable promptness on a request for prior authorization under parts 9505.5000 to 9505.5030 or on an authorization request under the second surgical opinion program, as established under part 9505.5090;

B. the department has denied a request for prior authorization under parts 9505.5000 to 9505.5030;

C. the department has denied an authorization request under the second surgical opinion program; or

D. the department has proposed a reduction in service as an alternative to authorization of a proposed service for which prior authorization under parts 9505.5000 to 9505.5030 was requested.

Subp. 2. **No right to appeal.** The right to appeal shall not apply to the list of surgical procedures established according to Minnesota Statutes, sections 256B.02, subdivision 8 and 256B.0625.

Subp. 3. **Request for fair hearing.** When a recipient requests assistance from a local agency in filing an appeal with the department, the local agency shall provide the assistance.

The request for a hearing must be submitted in writing by the recipient to the appeals unit of the department. The request must be filed either:

A. within 30 days of the date notice of denial of the request for prior authorization under parts 9505.5000 to 9505.5030 or request for authorization of a surgical procedure was received; or

B. no later than 90 days from the date notice of denial was received if the appeals referee finds there was good cause for the delay.

Subp. 4. **Fair hearing.** A referee shall conduct the hearing according to Minnesota Statutes, section 256.045, subdivision 4.

Subp. 5. **Commissioner's ruling.** Within 90 days of the date of receipt of the recipient's request for a hearing, the commissioner shall make a ruling to uphold, reverse, or modify the action or decision of the department or the medical review agent. The commissioner's ruling shall be binding upon the department and the recipient unless a request for judicial review is filed pursuant to Minnesota Statutes, section 256.045, subdivision 7.

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03

HIST: 10 SR 842; L 1988 c 689 art 2 s 268; 13 SR 1688; 19 SR 2433

STATE: MINNESOTA
Effective: July 1, 2005
TN: 05-03
Approved: MAY 18 2006
Supersedes: 96-08

Supplement 4 to Attachment 3.1-A

ALTERNATIVE HEALTH CARE PLANS

Minnesota enrolls recipients in ~~prepaid health plans~~ managed care organizations with which the State Medicaid agency contracts under the authority of §1903(m) and §1915(b) of the Act, and a §1115 waiver. Recipients are assured of access to services and of adequate quality through these contracts ~~which~~ that meet the requirements of 42 CFR §§434 and 438. The contracts require ~~prepaid health plans~~ managed care organizations to provide to enrollees the comprehensive health care services covered in Attachments 3.1-A and 3.1-B, except for the services listed in Attachment 3.1-F, item L, but ~~prepaid health plans~~ managed care organizations may also provide health care services in addition to the health care services in Attachments 3.1-A and 3.1-B when, in the judgment of the ~~prepaid health plans~~ managed care organizations, the provision of such services is medically necessary. The contracts also require the ~~prepaid health plans~~ managed care organizations to establish a quality assurance system under ~~42 CFR §434.34~~ 42 CFR §438, Subpart D.

STATE: MINNESOTA
Effective: January 1, 1998
TN: 98-12
Approved: 5/13/98
Supersedes: --

Supplement 5 to ATTACHMENT 3.1-A

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

PACE SERVICES

_x_ The State of Minnesota has not entered into any valid program agreements with a PACE provider and the Secretary of the Department of Health and Human Services.

___ The State of Minnesota has entered into a valid program agreement(s) with a PACE provider(s) and the Secretary, as follows:

Name of PACE provider: _____

Service area: _____

Maximum number of individuals to be enrolled: ____

Medical assistance covers medically necessary services and consultations delivered via ~~telemedicine~~ telehealth when performed by:

- a licensed or state registered health care provider;
- a mental health practitioner working under the supervision of a mental health professional;
- a certified community health worker;
- an alcohol and drug counselor;
- recovery peers;
- substance abuse disorder treatment coordinators
- mental health certified peer specialists and certified family peer specialists;
- rehabilitation workers in ARMHS;
- mental health behavioral aides operating in a CTSS program;
- federally qualified health centers and rural health centers including Indian Health providers; and
- providers qualified in accordance with par. 13(d) of Attachment 3.1-A to provide a comprehensive assessment for substance use disorder services, in the same manner as if the service or consultation was delivered in person.

Telehealth means the delivery of health care services or consultations through the use of real time two-way interactive video and visual or audio-only communication to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.~~Telemedicine~~ Telehealth includes the application of secure video conferencing, store and forward technology, and synchronous interactions between a ~~is the delivery of health care services while the~~ patient ~~is~~ at an originating site and ~~the~~ a health care provider ~~is~~ at a distant site. A communication between health care providers, or a health care provider and a patient that consists solely of mail, e-mail, or facsimile does not constitute ~~telemedicine~~ telehealth ~~services~~. ~~Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing, or store-and-forward technology, or via telephone when social distancing or quarantine is necessary either for the provider or the patient and video communication is not feasible.~~ Providers utilizing ~~telemedicine~~ telehealth must comply with criteria established by the Minnesota Department of Human Services in order to demonstrate that a quality assurance process and established protocols for patient safety have been addressed before, during, and after a particular service is delivered via telehealth~~telemedicine~~.

State of Minnesota

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(29) ___X__MAT as described and limited in Supplement __7__ to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

1905(a)(29) Medication-Assisted Treatment (MAT)

i. General Assurance

MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020, and ending September 30, 2025.

ii. Assurances

a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

c. The state assures coverage for all formulations of MAT drugs and biologicals for OUD that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

iii. Service Package

From October 1, 2020, through September 30, 2025, the state assures that MAT to treat OUD as defined at section 1905(ee)(1) of the Social Security Act (the Act) is covered exclusively under section 1905(a)(29) of the Act.

a. The state covers the following counseling services and behavioral health therapies as part of MAT.

Individual and Group Therapy

This service assists the beneficiary with achieving the goals developed in an individual opioid use disorder treatment plan and with the establishment of an individual recovery plan by identifying problems and implementing strategies to address, minimize, or reduce the inappropriate use and effects of chemicals through a combination of skills therapy, counseling, and service coordination. Therapy may also include consultation with relatives, guardians, close friends, and other treatment providers. Participation of non-Medicaid eligible persons is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

1905(a)(29) Medication-Assisted Treatment (MAT) (continued)

b. The following practitioners are qualified to provide this service within their scope of practice:

- Licensed alcohol and drug counselors;
- counselor supervisors of licensed alcohol and drug counselors;
- licensed social workers
- licensed marriage and family therapists; and
- licensed professional counselors.

c. The following is a brief summary of qualifications for each practitioner identified above:

Counselor supervisors of licensed alcohol and drug counselors must have three years of work experience as a licensed alcohol and drug counselor. Licensed professional counselors must have a master's degree which included 120 hours of a specified course of study in addition studies with 440 hours of post-degree supervised experience in the provision of alcohol and drug counseling.

Counseling and behavioral health therapies delivered as part of medication assisted treatment services are provided according to an individual recipient's treatment plan by an entity licensed by the Minnesota Department of Human Services to provide substance use disorder services or by a licensed professional in private practice.

1905(a)(29) Medication-Assisted Treatment (MAT) (continued)

iv. **Utilization Controls**

__X___ The state has drug utilization controls in place. (Check each of the following that apply)

___X__ Generic first policy
___X__ Preferred drug lists
___X_ Clinical criteria
___X__ Quantity limits

_____ The state does not have drug utilization controls in place.

v. **Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.**

There are no limitations on the amount, duration, or scope of MAT counseling and behavioral therapies. Oral buprenorphine is subject to quantity limits, and certain products and brands are included on the state's Preferred Drug List. Injectable and implantable buprenorphine are covered through the medical benefit with prior authorization.

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on October 24, 2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid state plan benefit for the period beginning October 1, 2020, and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 60). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State/Territory: MINNESOTA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

The following ambulatory services are provided.

See attached pages 2 through 32 for all services and limitations for the medically needy group.

***Description provided on attachment.**

State/Territory: MINNESOTA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO MEDICALLY NEEDY GROUP(S): SEE ATTACHMENT 2.2-A

1. Inpatient hospital services other than those provided in an institution for mental diseases.
Provided: __ No limitations x With limitations*

2.a. Outpatient hospital services.
Provided: __ No limitations x With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise covered under the plan)
Provided: __ No limitations x With limitations*

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
Provided: __ No limitations x With limitations*

3. Other laboratory and X-ray services.
Provided: __ No limitations x With limitations*

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
Provided: __ No limitations x With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*
Provided: x

c. Family planning services and supplies for individuals of childbearing age.
Provided: __ No limitations x With limitations*

c.(i) Individuals eligible under 1902(a)(10)(A)(ii)(XXI). Family planning services available to the general Medicaid population in paragraph 4.C above are the same as those provided to this group.

c.(ii) Family planning-related services provided to individuals described under Section 1902(a)(10)(A)(ii)(XXI) of the Social Security Act.
Provided: No limitations x With limitations*

* Description provided on attachment.

State/Territory: MINNESOTA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICAL NEEDY GROUPS(s): _____

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided: ___ No limitations _x_ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ___ No limitations _x_ With limitations:

* Description provided on attachment.

State/Territory: MINNESOTA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

/X/ Provided: / / No limitations /X/ With limitations*

b. Optometrists' Services

/X/ Provided: / / No limitations /X/ With limitations*

c. Chiropractors' Services

/X/ Provided: / / No limitations /X/ With limitations*

d. Other Practitioners' Services

/X/ Provided: / / No limitations /X/ With limitations*

7. Home Health Services

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

/X/ Provided: / / No limitations /X/ With limitations*

b. Home health aide services provided by a home health agency.

/X/ Provided: / / No limitations /X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

/X/ Provided: / / No limitations /X/ With limitations*

d. Physical therapy, occupational therapy, respiratory therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: / / No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: MINNESOTA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

8. Private duty nursing services.

/X/ Provided: /_/ No limitations /X/ With limitations*

9. Clinic services.

/X/ Provided: /_/ No limitations /X/ With limitations*

10. Dental services.

/X/ Provided: /_/ No limitations /X/ With limitations*

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: /_/ No limitations /X/ With limitations*

b. Occupational therapy.

/X/ Provided: /_/ No limitations /X/ With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

/X/ Provided: /_/ No limitations /X/ With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: /_/ No limitations /X/ With limitations*

b. Dentures.

/X/ Provided: /_/ No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: MINNESOTA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

c. Prosthetic devices.

☑ Provided: ___ No limitations _x_ With limitations*

d. Eyeglasses.

☑ Provided: ___ No limitations _x_ With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

☑ Provided: ___ No limitations _x_ With limitations*

b. Screening services.

☑ Provided: ___ No limitations _x_ With limitations*

c. Preventive services.

☑ Provided: ___ No limitations _x_ With limitations*

d. Rehabilitative services.

☑ Provided: ___ No limitations _x_ With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

☑ Provided: ___ No limitations _x_ With limitations*

b. ~~Skilled~~ nursing facility services.

☑ Provided: ___ No limitations _x_ With limitations*

* Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

c. Intermediate care facility services.

☒ Provided: ____ No limitations _x_ With limitations*
☐ Not provided.

15.a. ~~Intermediate care~~ Nursing facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)~~(A)~~ of the Act, to be in need of such care.

☒ Provided: ____ No limitations _x_ With limitations*
☐ Not provided.

b. ~~Including such~~ Intermediate care facility services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☒ Provided: ____ No limitations _x_ With limitations*
☐ Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ Provided: ____ No limitations _x_ With limitations*
☐ Not provided.

17. Nurse-midwife services.

☒ Provided: ___ No limitations _x_ With limitations*
☐ Not provided.

18. Hospice care (in accordance with section 1905(o) of the Act).

☒ Provided: ___ No limitations _x_ With limitations*
☐ Not provided.

* Description provided on attachment.

State: Minnesota

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S):

19. Case management services and tuberculosis related services

a. Case management services as defined in, and to the groups specified in, Supplements 1 through ~~1C~~ 1d to ATTACHMENT 3.1-B (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

x Provided: x With limitations*

___ Not provided.

b. Special tuberculosis (TB)-related services under section 1902(z)(2)(F) of the Act.

x Provided: x With limitations*

___ Not provided.

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

x Provided:[+] x Additional coverage[++]

b. Services for any other medical conditions that may complicate pregnancy.

x Provided:[+] x Additional coverage[++] ___ Not provided.

[+] Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

[++] Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

* Description provided on attachment.

State/Territory: MINNESOTA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

☐ Provided: ___ No limitations ___ With limitations*
☒ Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act.

☐ Provided: ___ No limitations ___ With limitations*
☒ Not provided.

23. Certified pediatric or family nurse practitioner' services.

☒ Provided: ___ No limitations x With limitations*

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

☒ Provided: ___ No limitations x With limitations*
☐ Not provided

b. Services of ~~Christian Science~~ nurses in religious nonmedical health care institutions.

☐ Provided: ___ No limitations ___ With limitations*
☒ Not provided.

c. Care and services provided in ~~Christian Science sanitoria~~ religious nonmedical health care institutions.

☒ Provided: x No limitations ___ With limitations*
☐ Not provided.

d. Nursing facility services provided for patients under 21 years of age.

☒ Provided: ___ No limitations x With limitations*
☐ Not provided.

* Description provided on attachment.

State/Territory: MINNESOTA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

24.e. Emergency hospital services.

☒ Provided: ___ No limitations _x_ With limitations*

☐ Not provided.

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described, and limited in Supplement 2 to Attachment 3.1-B, and Appendices A-G to Supplement 2 to Attachment 3.1-B.

☐ Provided ☒ Not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are: (A) authorized for the individual by a physician in accordance with a plan of treatment; (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (C) furnished in a home.

☒ Provided: ___ State approved (not physician) Service Plan allowed

_x_ Services outside the home also allowed

_x_ Limitations described on Attachment

☐ Not provided.

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 5 to Attachment 3.1-B.

☐ Provided ☒ Not provided

* Description provided on attachment.

State/Territory: MINNESOTA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

28. Freestanding Birth Center Services

☒ Provided: ___ No limitations _x_ With limitations*
☐ Not provided.

29. Integrated Care Models

☒ Provided: ___ No limitations _x_ With limitations*
☐ Not provided.

*Description provided on attachment.

LIMITATIONS TO THE AMOUNT, DURATION, AND SCOPE OF COVERED SERVICES (Referenced by the number of the service described in preceding pages)

1. Inpatient hospital services:

- Certification of admission is a condition of payment. Inpatient stays not deemed medically necessary by the state agency or the designated medical review agent are not covered.

- Inpatient chemical dependency treatment ~~will require at least 30 hours per week of therapy/counseling including group, collateral, and individual therapy/counseling~~ is provided according to state licensing and chemical dependency service requirements for individual client treatment that define treatment progress and continued clinical need.

- Hospitals must comply with federal regulations concerning informed consent and statements of acknowledgment for voluntary sterilization procedures, hysterectomies, and therapeutic abortions.

- Detoxification is covered only when inpatient hospitalization is medically necessary because of conditions resulting from withdrawal or conditions occurring in addition to withdrawal, e.g., conditions resulting from injury or accident or medical complications during detoxification such as delirium that necessitate the constant availability of physicians and registered nurses and/or complex medical equipment found only in an inpatient setting.

- Leave days, leaves of absence, and reserve beds are not covered.

- A private room must be certified by a licensed physician to be medically necessary, unless the hospitals private room rate does not exceed its semi-private room rate.

1. Inpatient hospital services. (continued)

- Abortion related services are covered: ~~when the abortion is medically necessary to prevent the death of a pregnant woman when such pregnant woman suffers from a physical disorder, injury or illness, and in cases where the pregnancy is the result of rape and incest. Cases of rape and incest must be reported to legal authorities unless the treating physician documents that the woman was physically or psychologically unable to report.~~
  (1) if the pregnancy is the result of an act of rape or incest; or
  (2) in the case where a person suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the person in danger of death unless an abortion is performed.

- Laboratory, x-ray, and any additional services provided as a result of a recipient's scheduled visit that immediately precedes hospital admission as an inpatient are not covered as separate services.

- Providers who administer pediatric vaccines as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

2. a. Outpatient hospital services.

- All services must be provided by or under the on-site supervision of a physician or dentist.
- Outpatient day treatment or partial hospital programs for mental illness require prior authorization ~~as specified in the *State Register*~~.
- Nutritional counseling ~~exceeding three visits requires prior authorization~~ is permitted as described in the Minnesota Health Care Program provider manual.
- Outpatient chemical dependency programs are provided for under rehabilitation services. Limitations for outpatient chemical dependency programs are provided under Item 13.d. of this attachment.
- Blood and blood components are covered to the extent these are not available from other sources. Blood charges may not exceed the cost of the quantity actually administered and not replaced.
- Outpatient hospital services includes end-stage renal disease hemodialysis. A recipient receiving hemodialysis in the home is considered to be receiving outpatient hospital services.
- Supplies and equipment ordinarily furnished by hospitals during the care and treatment of an illness or injury are not separately payable.
- Hospitals must comply with federal regulations concerning informed consent for voluntary sterilization procedures and hysterectomies.

2.a. Outpatient hospital services. (continued)

- Abortion related services are covered: ~~when the abortion is medically necessary to prevent the death of a pregnant woman when such pregnant woman suffers from a physical disorder, injury or illness, and in cases where the pregnancy is the result of rape and incest. Cases of rape and incest must be reported to legal authorities unless the treating physician documents that the woman was physically or psychologically unable to report.~~
  (1) if the pregnancy is the result of an act of rape or incest; or
  (2) in the case where a person suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the person in danger of death unless an abortion is performed.

- Coverage of physical therapy, occupational therapy, audiology, and speech language pathology is limited to services within the limitations provided under items 11.a. to 11,c., physical therapy and related services.

- Providers who administer pediatric vaccines as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program,

2.b. Rural and other ambulatory services that are covered under the plan and furnished by a rural health clinic.

- All health services provided by a rural health clinic are covered services within the limitations applicable to the same services as other medical assistance providers, if the rural health clinic's staffing requirements and written policies governing health services provided by personnel other than a physician are in compliance with 42 CFR §491.

- Providers who administer ~~the~~ pediatric vaccines ~~listed~~ as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC.

- All covered services are subject to the same limitations to amount, duration, and scope applicable to other providers of the same service.

- Providers who administer ~~the~~ pediatric vaccines ~~listed~~ as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

3. Other laboratory and x-ray services.

Coverage is limited to:

1) Laboratory services provided by ~~a Medicare certified laboratory. In addition, such services must be provided by~~ laboratories that comply with the requirements of §353 of the Public Health Service Act (the Clinical Laboratory Improvement Amendments (CLIA) of 1988. Pub. L. 100-578).

2) X-ray services provided by an x-ray vendor in compliance with 42 CFR §§ ~~§§~~486.100 to 486.110.

3) X-ray services provided by or at the request of a chiropractor are covered only when necessary to support a diagnosis of subluxation of the spine.

4.a. Nursing facility services for individuals age 21 or older (other than services in an institution for mental diseases):

- Residents must have their level of care certified by a physician, and must be determined by a long-term care consultation team to require the level of care provided in a nursing facility, prior to admission.

- Reserved-bed services are provided as indicated in Attachment 4.19-C.

- All medical equipment needed to provide routine services to residents must be supplied. Medical equipment that is not covered in the per diem rate, for which the need is identified and documented in the recipient's plan of care, and that is necessary for the continuous care and exclusive use of the recipient to meet an unusual medical need, can be separately reimbursed.

- Prior to admission to a nursing facility, all applicants must be screened and have a Level I identification screen to determine possible mental illness or mental retardation.

- If an individual with mental illness or mental retardation is admitted to a nursing facility without being screened and having a Level II evaluation and does not meet the exemptions for certain hospital discharges, the person must be screened before Medical Assistance will reimburse the facility.

- Influenza and pneumococcal immunizations for adults are an exception to the requirement that physicians must sign and date all orders. If there is a standing order for these immunizations, they may be administered by licensed health care professionals trained to: 1) screen residents for contraindications to vaccination; 2) administer vaccines; and 3) monitor residents for adverse events, in accordance with state and local regulations. Administration of immunizations pursuant to a standing order must be according to facility policy developed in consultation with a physician.

4.a. Early and periodic screening, diagnosis, and treatment services:

- Early and periodic screening, diagnosis and treatment service is a service provided to a recipient under age 21 to detect, prevent, and correct physical andmental conditions or illnesses discovered by screening services, and to provide diagnosis and treatment for a condition identified according to 42 CFR 441.50 andaccording to section 1905(r) of the Social Security Act.
- Initial and periodic screenings are provided as indicated by the periodicity schedule. Inter-periodic screens are available to recipients based on medical necessity. An EPSDT service can be requested by the recipient or performed by a provider at any time if medically necessary.
- Initial face-to-face and written notifications of recipients are followed up bycounty agencies with telephone contacts, letters, and/or home visits. Annual orperiodic written notifications may also be supplemented by personal contacts.
- Drugs that are considered investigational, drugs that are provided to a recipient during the clinical trial designed to test the efficacy of the provided drug, or drugs that have not been approved for general use by the U.S. Food and Drug Administration are not covered.

A diagnostic assessment is a written report that documents clinical and functional face-to-face evaluation of a recipient's mental health, including the nature, severity and impact of behavioral difficulties, functional impairment, and subjectivedistress of the recipient, and identifies the recipient's strengths and resources. A diagnostic assessment is necessary to determine a recipient's eligibility for mental health services.

~~An interactive diagnostic assessment, usually performed with children, may use physical aids and nonverbal communication to overcome communication barriers becausethe recipient demonstrates one of the following:~~

- ~~Has lost or has not yet developed either the expressive language communicationskills to explain his/her symptoms and response to treatment~~
- ~~Does not possess the receptive communication skills needed to understand the mental health professional if he/she were to use adult language for communicationor~~
- ~~Needs an interpreter, whether due to hearing impairment or the recipient's language is not the same as the provider's, in order to participate in thediagnostic assessment~~

Brief Diagnostic Assessment

The Brief Diagnostic Assessment includes a written ~~clinical summary~~ evaluation that explains the diagnostic hypothesis which may be used to address the recipient's immediate needs or presenting problem. The assessment collects sufficient information to apply a provisional clinical hypothesis. A brief diagnostic must not be used for a child under six years of age. Components includes:

- ~~The recipient's current life situation~~ Age
- Recipient's description of symptoms (including reason for referral)
- History of mental health treatment
- Cultural influences on the client, and
- A mental status exam

~~Screenings used to determine a recipient's substance use, abuse, or dependency,and other standardized screening instruments~~

Standard Diagnostic Assessment

- All components of Brief Diagnostic assessment, the client's: current living situation, status of basic needs, education level, employment status, current medications, immediate risks to health and safety, and perceptions of their own condition.
- Screenings used to determine a recipient's substance use, abuse, or dependency
- Conducted in the cultural context of the recipient
- An assessment of the recipient's needs based on baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety
- Assessment methods and use of standardized assessment tools ~~Clinical summary~~ diagnostic formulation, recommendations, and prioritization of needed mental health, ancillary or otherservices

4.b. Early and periodic screening, diagnosis, and treatment services, continued:

- Involvement of the recipient and recipient's family in assessment and service preferences and referrals to services
- Sufficient recipient data to support findings on all axes of the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)or the Diagnostic Classification of Mental Health and DevelopmentalDisorders of Infancy and Early Childhood, and any differential diagnosis

~~**Extended Diagnostic Assessment**~~

- ~~All requirements of a Standard Diagnostic Assessment, which are gathered over three or more appointments due to the recipient's complex needs thatnecessitate significant additional assessment time.~~
- ~~Complex needs are those caused by:~~
  - ~~o Acuity of psychotic disorder~~
  - ~~oCognitive or neurocognitive impairment~~
  - ~~oA need to consider past diagnoses and determine their current applicability~~
  - ~~o Co-occurring substance abuse use disorder~~
  - ~~o Disruptive or changing environments,~~
  - ~~o Communication barriers~~
  - ~~o Cultural considerations~~

~~An adult diagnostic assessment update can only be an update of a standard or extended diagnostic assessment for individuals age 18 and older. It updates the most recent diagnostic assessment. The update:~~

- ~~Reviews recipient's life situation: updates significant new or changed information, documents where there has not been significant change~~
- ~~Screens for substance use, abuse, or dependency~~
- ~~Mental status exam~~
- ~~Assesses recipient's needs based on baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, safety needs~~
- ~~Includes a clinical summary~~
- ~~Includes recommendations and prioritization of needed mental health, ancillary, or other services~~
- ~~Includes involvement of recipient and recipient's family in assessment and service preferences and referrals to services~~
- ~~Includes diagnosis on all axes of the current edition of the DSM~~

The following are in excess of Federal requirements:

- Screened recipients receive a written copy of any abnormal screening findings.

The following health care not otherwise covered under the State Plan is covered for children by virtue of the EPSDT provisions of Title XIX:

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

3. **Children's therapeutic services and supports** for children is a package of mental health services for children that includes varying levels of therapeutic and rehabilitative intervention provided by mental health professionals, clinical trainees, ~~and~~ mental health practitioners, mental health certified family peer specialists, and mental health behavioral aides ~~under the clinical supervisionof mental health professionals,~~ in order to treat a diagnosed emotional disturbance or mental illness. The interventions are delivered using various treatment modalities and combinations of services designed to realize treatment outcomes identified in a recipient's individual treatment plan. Treatment staff who are not mental health professionals receive treatment supervision from a mental health professional.

A diagnostic assessment by a mental health professional or ~~mental health practitioner~~ clinical trainee as described in item 6.d.A, must have determined that the child is in need of children's therapeutic services and supports to address an identified disability and functional impairment. A child may be determined to be eligible for up to five days of children's therapeutic services and supports day treatment, based on a hospital's medical history and presentation examination of the child.

Qualified children's therapeutic services and supports providers can provide diagnostic assessment, explanation of findings, psychological testing and neuropsychological services.

The following are eligible to provide children's therapeutic services and supports:

A. A county-operated or non-county operated entity certified by the Department

B. A facility of the Indian Health Service or a facility owned or operated by a tribe or tribal organization and funded by either Title I of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, P.L. 106-260, operating as a 638 facility. A facility of the Indian Health Service or a 638 facility must be certified by the Department.

Provider Qualifications and Training

A. A mental health professional is an individual defined in item 6.d.A.

B. A mental health practitioner working under the direction of a mental health professional:

1) holds a bachelor's degree in one of the behavior sciences or related fields from an accredited college or university, works in a day treatment program, and:

a. has at least 2,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbance~~s~~ or mental illness;

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

d) is fluent in the non-English language of the ethnic group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to clients with mental illness or emotional disturbance~~s~~, and receives clinical supervision from a mental health professional at least once a week until the requirement of 2,000 hours of supervised experience is met; or
e) receives 40 hours of training in the delivery of services to clients with mentalillness or emotional disturbance within the first six months of employment, and receives weekly supervision from a mental health professional until he or she has 2,000 hours of supervised experience. Or,

2) has at least ~~4~~,000 hours of supervised experience in the delivery of services to children with emotional disturbance~~s~~, mental illness, or substance use disorder, including hours worked as a mental health behavioral aide I orII; a practitioner with 2,000 hours of supervised experience must receive weekly supervision from a mental health professional until he or she has 4,000 hours of supervised experience; or
3) has at least 4,000 hours of supervised experience in the delivery of services to children with traumatic brain injury or developmental disabilities, and completes Department required training on mental illness and emotional disturbance. A practitioner with 2,000 hours of supervised experience must receive weekly supervision from a mental health professional until he or she has 4,000 hours of supervised experience; or
4) is a graduate or undergraduate student in one of the behavioral sciences or related fields and is formally assigned by an accredited college or university to an agency or facility for clinicaltraining; or
5) holds a master's or other graduate degree in one of the behavioral sciences or related fields from an accredited college or university; or
6) holds a bachelor's degree in one of the behavioral sciences or related fields, and completes a practicum or internship that requires direct interaction with children and is focused on behavioral sciences or a related field; or

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

~~7) is working as a clinical trainee as described in item 6.d.A.~~

C. A mental health behavioral aide, a paraprofessional who is not the legal guardian or foster parent of the child, working under the direction of a mental health professional or a mental health practitioner under the clinical supervision of a mental health professional.

1) Level I mental health behavioral aides must:
a. be at least 18 years of age; and
~~b.~~ have a high school diploma or general equivalency diploma (GED) or two years of experience as a primary caregiver to a child with severe emotional disturbance or mental illnesswithin the previous ten years; and
~~c. meet the following orientation and training requirements:~~

~~i. 30 hours of preservice training covering Minnesota's data privacy law; the provisions of Minnesota's Comprehensive Children's Mental Health Act; the different diagnostic classifications of emotional disturbance; the use of psychotropic medications in children and the potential side effects; the core values and principles of the Child Adolescent Service System Program; how to coordinate services between the public education system and the mental health system; how to provide culturally appropriate services; and how to provide services to children with developmental disabilities or other special needs.~~

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

Fifteen hours must be face-to-face training in mental health services delivery and eight hours must be parent team training, which includes partnering with parents; fundamentals of family support; fundamentals of policy and decision-making; defining equal partnership; complexities of parent and service provider partnership in multiple service delivery systems; sibling impacts; support networks; and community resources; and 20 hours of continuing education every two calendar years. Topics covered are those identified in subclause i., above.

1) a Level II mental health behavioral aide must:

1) be at least 18 years of age;
2) have an associate or bachelor's degree or 4,000 hours of experience delivering clinical services to children with mental illness or emotional disturbance, or complete a certification program approved by the Department; and
3) meet the preservice and continuing education requirements as a Level I mental health behavioral aide.

B. A day treatment multidisciplinary team that includes at least one mental health professional ~~and one mental health practitioner~~.

Components of Children's Therapeutic Services and Supports

Persons providing children's therapeutic services and support must be capable of providing the following components:

A. Psychotherapy: patient and/or family, family, and group. Family psychotherapy services must be directed exclusively to the treatment of the child. ~~Psychotherapy services require prior authorization.~~
B. Individual, family, or group skills training designed to facilitate the acquisition of psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory that was disrupted by psychiatric illness.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

~~Fifteen hours must be face-to-face training in mental health services delivery and eight hours must be parent team training, which includes partnering with parents; fundamentals of family support; fundamentals of policy and decision-making; defining equal partnership; complexities of parent and service provider partnership in multiple service delivery systems; sibling impacts; support networks; and community resources; and~~

~~i. 20 hours of continuing education every two calendar years. Topics covered are those identified in subclause i., above.~~

2) a Level II mental health behavioral aide must:

1) be at least 18 years of age;
2) have an associate or bachelor's degree ~~or 4,000 hours of experience delivering clinical services~~ to children with ~~in the treatment of mental illness~~ or emotional disturbance ~~concerning children or adolescents~~, or complete a certification program approved by the Department; and
~~3) meet the preservice and continuing education requirements as a Level I mental health behavioral aide.~~

D. A day treatment multidisciplinary team that includes at least one mental health professional and one mental health practitioner.

E. A clinical trainee

A clinical trainee, mental health practitioner, certified family peer specialist, or mental heath behavioral aide must have at least 30 hours of continuing education every two years, as described by state law.

A clinical trainee, mental health practitioner, certified family peer specialist, or mental heath behavioral aide must perform all services described under the supervision of a mental health professional and have a written treatment supervision plan, developed within 30 days of employment and updated annually.

Each staff person's treatment supervision plan must include:

(1) the name and qualifications of the staff person receiving treatment supervision;

(2) the names and licensures of the treatment supervisors who are supervising the staff person;

(3) how frequently the treatment supervisors must provide treatment supervision to the staff person; and

(4) the staff person's authorized scope of practice, including a description of the client population that the staff person serves, and a description of the treatment methods and modalities that the staff person may use to provide services to clients.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

Components of Children's Therapeutic Services and Supports

Persons providing children's therapeutic services and support must be capable of providing the following components:

B. Psychotherapy: patient and/or family, family, and group. Family psychotherapy services must be directed exclusively to the treatment of the child. Psychotherapy services require prior authorization.

C. Individual, family, or group skills training designed to facilitate the acquisition of psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory that was disrupted by psychiatric illness.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

B. Crisis planning. Crisis planning services focus on crisis identification and prevention and is 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 coping mechanisms, or the presentation of danger to self or others. The services help the child, the child's family and all providers of services to the child to:

1) recognize factors precipitating a mental health crisis;
2) identify behaviors related to the crisis; and
3) be informed of available resources to resolve the crisis.

Crisis planning services must be coordinated with emergency services. Emergency services must be available 24 hours per day, seven days a week;

C. Mental health behavioral aide services means medically necessary one-on-one activities performed by a trained paraprofessional to practice psychosocial skills and assist a child retain or generalize psychosocial skills according to the child's treatment plan that a mental health professional, clinical trainee, or mental health practitioner has previously taught to the child according to the child's treatment plan.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

C. direction of a mental health behavioral aide by a mental health professional, a clinical trainee, ~~who assumes full professional responsibility,~~ or ~~direction of a mental health behavioral aide~~ by a mental health practitioner working under the clinical supervision of a mental health professional ~~who assumes full professional responsibility~~. Direction is based on the child's individualized treatment plan and means ensure performance of activities in guiding the mental health behavioral aide in providing services to a client and continuously evaluate the mental health behavioral aide's ability to carry out the MHBA activities in the individualized treatment plan.~~:~~

~~1) ongoing, on-site observation by a mental health professional or mental health practitioner for at least one hour during every 40 hours of service; and~~

~~2) immediate accessibility of the mental health professional or mental health practitioner to the mental health behavioral aide when the services are provided.~~

D. mental health service plan development includes the development, review, and revision of a child's individual treatment plan;

E. ~~Functional assessment.~~ ~~A functional assessment is the administration and reporting of standardized outcome measurement instruments.~~

Components A-B, above, may be combined to constitute a mental health day treatment program, provided by a multidisciplinary staff under the clinical supervision of a mental health professional. A day treatment program consists of psychotherapy for three or more recipients and individual or group skills training. It is provided by an outpatient hospital accredited by the Joint Commission on the Accreditation of Healthcare Organizations, a community mental health center, or a county contracted day treatment provider. ~~Day treatment is provided at least one day a week for a minimum two-hour time block (of which one hour, is individual or group psychotherapy), but no more than three hours per day.~~ A child may receive less than two hours per day of day treatment if the child is transitioning in or out of day treatment.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

The services specified in items A through F below are **not** eligible for Medical Assistance payment:

A. Service components of children's therapeutic services and supports simultaneously provided by more than one provider entity.
B. Children's therapeutic services and supports not provided by Minnesota's Medicaid program.
C. 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.
D. Services that are the responsibility of a residential or program license holder, including foster care providers.
E. More than 15 hours of children's therapeutic services and supports provided within a six-month period to a child with severe emotional disturbance who is residing in a hospital, ~~a group home,~~ a residential treatment facility, psychiatric residential treatment facility, or other institutional group setting or who is participating in a partial hospitalization program, if part of a discharge plan.
F. Simultaneous treatment of an individual recipient by multiple mental health professionals, multiple mental health practitioners, or multiple behavioral aides for the same purpose.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

~~Telemedicine services.~~ ~~Children's therapeutic services and supports that are otherwise covered as direct face-to-face services may be provided via two-way, interactive video if medically appropriate to the condition and needs of the recipient.~~

4. **Crisis response services** for children are services recommended by a physician, mental health professional or clinical trainee as defined ~~for children's therapeutic services and support~~ in 6.a, or a mental health practitioner as defined for **children's therapeutic services and supports.** For purposes of item 4.b., a child eligible for crisis response servicesmeans a child under age 21 who:

A. is screened as possibly experiencing a mental health crisis where a crisis assessment is needed; and
B. is assessed as experiencing a mental health crisis and mobile crisis intervention or crisis stabilization services are necessary.

The following are eligible to provide crisis response services:

D. An entity operated by a county.

E. An entity under contract with a county.

F. A facility of the Indian Health Service or a facility owned or operated by a tribe or tribal organization and funded by either Title I of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, P.L. 106-260, operating as a 638 facility.

Training and provider standards

A crisis provider must have at least one mental health professional on staff at all times and at least one additional staff member capable of leading a crisis response in the community.Members of the team provide only those crisis services that arewithin their scope of practice, and under the supervision required by state law.

Crisis assessment and intervention must be available 24 hours a day, seven days a week. However, if a county provider demonstrates to the satisfaction of the Department that, due to geographic or other barriers, it cannot provide services 24 hours a day, seven days a week, the Department may approve a county provider based on an alternative plan proposed by a county or groups of counties. The alternative plan must be designed to 1)result in increased access and reduction in disparities in the availability of crisis services; and 2)provide mobile services outside of normal business hours and on weekends and holidays.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

Components of Crisis Response Services

Persons providing crisis response services must be capable of providing the following components:

B. Crisis assessment. Crisis assessment is an immediate face-to-face assessment by a physician, mental health professional, clinical trainee, or mental health practitioner under the ~~clinical~~ supervision of a mental health professional, following a screening that suggests the child may be experiencing a mental health crisis or mental health emergency.

The crisis assessment is an evaluation of any immediate needs for which emergency services are necessary and, as time permits, the recipient's life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning. ~~Crisis assessment services must be available 24 hours a day, seven days a week. However, if a county provider demonstrates to the satisfaction of the Department that, due to geographic or other barriers, it cannot provide crisis assessment 24 hours a day, seven days a week, the Department may approve a county provider based on an alternative plan proposed by a county or groups of counties. The alternative plan must be designed to 1)result in increased access and reduction in disparities in the availability of crisis services; and 2)provide mobile services outside of normal business hours and on weekends and holidays.~~

B. Crisis intervention. Crisis intervention is a face-to-~~fact~~face, short- term intensive mental health service provided during a mental health crisis or mental health emergency to help a recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning. Crisis intervention must be provided on-site by a mobile crisis intervention team ~~outside of an emergency room, urgent care, or inpatient hospital setting~~. Services delivered to a beneficiary while admitted to an inpatient hospital are excluded from coverage under this section ~~Crisis intervention must be available 24 hours a day, seven days a week. However, if a county provider demonstrates to the satisfaction of the Department that, due to geographic or other barriers, it cannot provide crisis intervention 24 hours a day, seven days a week, the Department may approve a county provider based on an alternative plan proposed by a county or groups of counties. The alternative plan must be designed to 1)result in increased access and reduction in disparities in the availability of crisis services; and 2)provide mobile services outside of normal business hours and on weekends and holidays.~~

2) Crisis intervention is provided after the crisis assessment.

Crisis intervention includes developing an initial,

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

brief crisis treatment plan not later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided. The plan must be updated as needed to reflect current goals and services.

The crisis intervention team must document which short-term goals were met, and when no further crisis intervention services are required.

~~1) The crisis intervention team is comprised of at least two mental health professionals, or a combination of at least one mental health professional and one mental health practitioner with the required crisis training and under the clinical supervision of a mental health professional on the team. The team must have at least two members, with at least one member providing on-site crisis intervention services when needed.~~

2) If possible, at least two members of the crisis intervention team must confer in person or by telephone about the assessment, crisis treatment plan, and necessary actions taken.

~~3) If crisis intervention services continue into a second calendar day, a mental health professional must contact the client face-to-face on the second day to provide services and update the crisis treatment plan.~~

4) If the recipient's crisis is stabilized, but the recipient's needs a referral for mental health crisis stabilization or other services, the team must provide referrals to these services.

5) If crisis stabilization is necessary, the crisis intervention team must complete the individual treatment plan recommending crisis stabilization. If there is an inpatient ~~or urgent care visits~~visit, the plan is completed bystaff of the facility.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

C. Crisis stabilization. Crisis stabilization is an individualized mental health service designed to restore a recipient to the recipient's prior functional level.

1) Crisis stabilization cannot be provided without first providing crisis intervention.

2) Crisis stabilization is provided by a mental health professional or a mental health practitioner working under the clinical supervision of a mental health professional and for a crisis stabilization services provider. Mental health practitioners must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

3) Crisis stabilization may be provided in a recipient's home, another community setting, or a supervised licensed residential programs that is not an IMD that provides short-term services if the service is not included in the facility's reimbursement.

4) A crisis stabilization treatment plan must be developed, and services must be delivered according to the plan. If clinically appropriate, the recipient must participate in the development of the plan. The plan must be completed within 24 hours of beginning services and developed by a mental health professional or a mental health practitioner under the clinical supervision of a mental health professional. At a minimum, the plan must contain:

a) a list of problems identified in the assessment;

b) a list of the recipient's strengths and resources:

c) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement of the goals;

d) specific objectives directed toward the achievement of each goal;

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

e) documentation of the participants involved in the service planning;

f) planned frequency and type of services initiated;

g) the crisis response action plan should a crisis occur; and

h) clear progress noted on the outcome of the goals.

~~**Telemedicine services.** Crisis response services for children that are otherwise covered as direct face-to-face services may be provided via two-way, interactive video if medically appropriate to the condition and needs of the recipient.~~

The services specified in items A through I below are **not** eligible for Medical Assistance payment:

A. Recipient transportation services.
B. Services provided by a nonenrolled Medical Assistance provider.
C. Room and board.
D. Services provided to a recipient admitted to an inpatient hospital.
E. Services provided by volunteers.
F. Direct billing of time spent "on call" when not providing services.
G. Provider service time paid as part of case management services.
H. Outreach services, which are services identifying potentially eligible people in the community, informing potentially eligible people of the availability of mental health crisis response services, and assisting potentially eligible people with applying for these services.
I. A mental health service that is not medically necessary.

Pages 17n through 17nn are intentionally omitted.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

~~I. A mental health service that is not medically necessary.~~

3. **Services provided to recipients with severe emotional disturbance residing in a children's residential treatment facility** are provided by a county-operated or non-county operated entity, under contract with the county or a tribally operated entity and are limited to:

A. Intake, treatment planning and support. This includes developing, monitoring and revising the treatment plan, recording the recipient's medical history, providing a basic health screening and referring for health services if necessary, assisting in implementing health regimes, medication administration and monitoring, coordinating home visits when consistent with treatment plan goals, coordinating discharge and referral for aftercare services, and travel and paperwork related to intake, treatment planning and support.

B. Psychological examinations, case consultation, individual and group psychotherapy, and counseling. Includes testing necessary to make these assessments.

C. Skills ~~development~~training. This means therapeutic activities designed to restore developmentally appropriate functioning in social, recreational, and daily living skills. It includes structured individual and group skills building activities.

It also includes observing the recipient at play and in social situations, and performing daily living activities and engaging in on-the-spot intervention and redirection of the recipient's behavior consistent with treatment goals and age-appropriate functioning.

D. Family psychotherapy and skills training designed to improve the basic functioning of the recipient and the recipient's family in the activities of daily and community living, and to improve the social functioning of the recipient and the recipient's family in areas important to the recipient's maintaining or reestablishing residency in the community. This includes assessing the recipient's behavior and the family's behavior to the recipient, activities to assist the family in improving its understanding of normal child

4.b. Early and periodic screening, diagnosis, and treatment services. (continued)

development and use of parenting skills to help the recipient achieve the goals of the treatment plan, and promoting family preservation and unification, community integration, and reduced use of unnecessary out-of-home placement or institutionalization. Family psychotherapy and skills training is directed exclusively to treatment of the recipient.

Covered services are:

1. Provided pursuant to an individual treatment plan based on recipients' clinical needs;

2. Developed with assistance from recipients' families or legal representatives; and

3. Supervised by a mental health professional who provides ~~at least weekly face-to-face~~ supervision either individually or as a group to staff providing program services to a resident.

Provider Qualifications and Training

Members of the multidisciplinary team provide residential rehabilitative services within their scope of practice under the supervision of a mental health professional as defined in item 6.d.

4.b. Early and periodic screening, diagnosis, and treatment services. (continued)

4. Personal care assistant services identified in an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) under the Individuals with Disabilities Education Act (IDEA) and provided by school districts to children during the school day**.**

The services must meet all the requirements otherwise applicable under item 26 of this Attachment if the service had been provided by a qualified, enrolled provider other than a school district, with the following exceptions:

A. a personal care assistant need not be an employee of a personal care provider organization;

B. assessments, reassessments and service updates are not required;

C. Department prior authorization is not required;

D. a personal care assistant provides services under the direction of a qualified professional which includes registered nurses, public health nurses, licensed school nurses, mental health professionals, physical therapists, occupational therapists, speech language pathologists, audiologists or physicians, as designated in the IEP;

E. PCA Choice is not an option.

To use an authorized home care personal care assistant at school, the recipient or responsible party must provide written authorization in the recipient's care plan identifying the chosen provider and the daily amount of services to be used at school.

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

5. **Youth Assertive Community Treatment (Youth ACT)** is intensive nonresidential rehabilitative mental health services recommended by a mental health professional defined in item 6.d.A. after a diagnostic assessment and a level-of-care determination, using an instrument approved by the Department, which indicates a need for intensive integrated intervention without 24-hour medical monitoring and a need for extensive collaboration among multiple providers.

   Recipients must be diagnosed with a serious mental illness or co-occurring substance abuse addiction. Additionally, recipients must have either a:

   A. Functional impairment, and
      1) a history of difficulty in functioning safely and successfully in the community, school, home, or job; or
      2) be likely to need future services from the adult mental health system; or
   B. Recent diagnostic assessment that documents that intensive nonresidential rehabilitative mental health services are medically necessary to ameliorate identified symptoms and functional impairments and to achieve individual transition goals.

   The following are eligible to provide youth ACT services:

   A. An entity contracting with the Department.
   B. A facility of the Indian Health Service or a facility owned or operated by a tribe or tribal organization and funded by either Title I of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, P.L. 106-260, operating as a 638 facility.

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

Provider Qualifications, Training and Supervision

Youth ACT services are provided by a multidisciplinary staff using a total team approach and assertive outreach for treatment in a recipient's environment. The team includes a clinical supervisor who is a mental health professional as defined in item 6.d.A and other staff consistent with the Minnesota Youth ACT treatment standards, which will be published by the Department and available on the Department's website at www.dhs.state.mn.us.
The multidisciplinary team must include:

A. A mental health professional as defined in item 6.d.A.
B. A mental health practitioner as defined in item 4.b.
C. A mental health case manager as defined in item E.1. of Supplement 1 to Attachment 3.1-B.
D. A certified peer support specialist who~~:~~ meets the definition in 3.d.3 and is also a former children's mental health consumer.
   ~~a. Must be at least 22 years of age;~~
   ~~b. Has a high school diploma or equivalent;~~
   ~~c. Has had a diagnosis or mental illness, or co-occurring mental illness and substance abuse addiction and is willing to disclose that history to team members and clients;~~
   ~~d. Must be a former consumer of child mental health services, or a former or current consumer of adult mental health services, for a period of at least two years.~~
   ~~e. Successfully completed peer specialist certification training that includes specific skills relevant to providing peer support to other consumers, parent-teaming training, and training specific to child development.~~
   ~~f. Must complete 30 hours of relevant continuing education each calendar year in topics such as children's mental and physical health, educational development, and culture.~~

E. A clinical trainee, as defined in item 6.d.A

4.c. Early and periodic screening, diagnosis, and Treatment services. (continued)

The team must provide the following:

A. individual, family and group psychotherapy;
B. individual, family and group skills training;
C. crisis ~~assistance~~ planning;
D. medication management;
E. mental health case management;
F. medication education services;
G. care coordination;
H. psychoeducation of and consultation and coordination with the client's biological, adoptive, or foster family; in the case of a youth living independently, the client's immediate non-familial support network;
I. clinical consultation to a recipient's employer, school, other social service agencies, housing providers, and to the courts to assist in managing the mental illness or co-occurring disorder and to develop client support systems;
J. coordination with, or performance of, crisis intervention and stabilization services;
K. assessment of a client's treatment progress and effectiveness of services using standardized outcome measures published by the Department;
L. transition services;
M. co-occurring substance use disorder ~~integrated dual disorders~~ treatment;
N. peer support services;
O. housing access support.

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

The services below are not eligible for medical assistance payment as youth ACT services:

A. recipient transportation services otherwise paid under this Attachment;
B. services billed by a non-enrolled Medicaid provider;
C. services provided by volunteers;
D. direct billing of days spent "on call" when not providing services;
E. job-specific skills services, such as on-the-job training;
F. performance of household tasks, chores, or related activities for the recipient;
G. outreach services, as defined for adult rehabilitative mental health services on page 53g;
H. inpatient psychiatric hospital treatment;
I. mental health residential treatment;
J. partial hospitalization;
K. physician services outside of care provided by a psychiatrist serving as a member of the treatment team;
L. room and board costs;
M. children's mental health day treatment services;
N. mental health behavioral aid services.

4. Child and Family Psychoeducation Services provide information or demonstration to an individual or family as part of an individual, family, multifamily group, or peer group session. Family psychoeducation services explain, educate, and support the child and family in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development. Services are provided so that the individual, family, or group can help the child prevent relapse and the acquisition of comorbid disorders, while achieving optimal mental health and long-term resilience. Child and fFamily psychoeducation services are provided by a mental health professional, ~~or a mental health practitioner working as~~ a clinical trainee, or a mental health practitioner as defined in Item 6.d.A.

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

5. **In-reach Care Coordination** services, as described in items 5.a. and 6.d.A., and provided to children with a serious emotional disturbance who have frequented a hospital emergency room two or more times in the previous consecutive three months, or been admitted to an inpatient psychiatric unit two or more times in the previous consecutive four months, or is being discharged from either facility to a shelter.

6. **Mental Health Clinical Care Consultations** are communications from a treating mental health professional, or treating ~~mental health practitioner working as a~~ clinical trainee, as defined in Item 6.d.A., to other providers or educators not under the ~~clinical~~ supervision of the treating mental health professional who are working with the same recipient. Recipients have been diagnosed with a complex mental health condition or a mental health condition that co-occurs with other complex and chronic conditions. The communications inform, inquire, and instruct regarding the client's symptoms; provide strategies for effective engagement, care, and intervention needs; describe treatment expectations across service settings; and direct and coordinate clinical service components provided to the client and family.

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

7. **Certified Family Peer Specialists** provide services within an existing mental health community provider setting to recipients diagnosed with emotional disturbance, or severe emotional disturbance. Services may be provided to the child's parents or legal guardians if those services are directed exclusively toward the benefit of the child.

Provider Qualifications and Training: a certified family peer specialist must:

A. Be at least ~~21~~ 18 years of age;
B. Have raised, or are currently raising a child with a mental illness;
C. Have experience navigating the children's mental health system;
D. Successfully complete peer specialist certification training approved by the Department that teaches participating consumers specific skills relevant to providing peer support to other parents.

Components of Family Peer Specialist Services

Certified family peer specialists provide the following services that are recommended by a mental health professional, as defined in item 6.d.A, or a physician:

A. nonclinical family peer support counseling;
B. collaboration with other care providers;
C. non-adversarial advocacy;
D. promotion of the individual family culture in the milieu;
E. initiation of interaction amongst parents in the community;
F. support and guidance to promote resiliency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services;
G. education to parents in developing coping mechanisms, problem-solving skills, availability of community resources, and mental illness in general; and
H. establishment of peer led parent support groups;

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

10. **Early Intensive Developmental and Behavioral Intervention (EIDBI)**. EIDBI services are medically necessary, intensive treatment provided to promote the child's optimal independence and participation in family, school and community life; EIDBI services educate and support families, reduce stress, and improve long-term outcomes and quality of life for children and their families.

EIDBI provides a range of individualized, medically necessary intensive developmental and behavioral interventions to address or treat, in a comprehensive manner, the functional skills and core deficits of autism spectrum disorder (ASD) and other related conditions that cause persistent, clinically significant impairment in social communication and behavioral interaction and other areas of functional development for which this service is medically appropriate. Skill development focuses on the following domains: self-regulation, self-care, behavioral challenges, expressive communication, receptive communication, cognitive functioning, and safety. ~~social/interpersonal interactions, verbal and non-verbal communication, cognition, learning and play, adaptive, self-help skills, and behavioral self-regulation~~.

Services must be provided directly to the child.~~, or on behalf of the child, by~~ Family/caregiver training may be provided to the child's parents/caregivers for the benefit of the child.

A **comprehensive multi-disciplinary evaluation (CMDE)** must be completed to determine medical necessity of EIDBI services. The CMDE must include:

- Assessment of the child's degree of severity of core features of ASD and related conditions, as well as other areas of functional development including, self-regulation, self-care, behavioral challenges, expressive communication, receptive communication, cognitive functioning, and safety ~~cognition, learning and play, social/personal interaction, verbal and non-verbal communication, adaptive, self-help, behavioral self-regulation, and motor development~~;
- Review and incorporation of the diagnosis and other related assessment information from other qualified professionals, including information gathered from family members, child care providers, as well as any medical or assessment information from other licensed professionals working with the child such as the child's rehabilitation therapists, licensed school personnel, or other mental health professionals;

4.c. Early and periodic screening, diagnosis, and Treatment services. (continued)

- Identification of parent/caregiver preferences and family culture, language, goals and values; and
- Assessment of the type and level of parent/caregiver training and involvement preferred.

Qualified CMDE Provider: A licensed mental health professional, as described in item 6.d.A of Attachments 3.1-A and 3.1-B, ~~a mental health practitioner working as~~ a clinical trainee and under the supervision of a psychiatrist or mental health professional, or a physician is qualified to provide the CMDE. Providers must:

A. Have at least 2,000 hours of clinical experience in the evaluation and treatment of children with ASD or a related condition, or equivalent documented course-work at the graduate level by an accredited university in the following content areas: ~~ASD~~ diagnosis and treatment strategies related to ASD and related conditions, and child development;
B. Be able to diagnose and/or provide treatment; and
C. Work within their scope of practice and professional license.

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

Provider Qualifications and Training.

Qualified Supervising Professional: All EIDBI services must be billed by, and either provided by or under the clinical supervision of a qualified supervising professional who assumes full professional responsibility for the services provided by Level I, II and III EIDBI providers. A qualified supervising professional is a mental health professional, as described in item 6.d.A, or a Licensed Board-Certified Behavior Analyst.

Qualified supervising professionals must work within their licensed scope of practice, and have at least 2,000 hours of supervised, clinical experience and/or training in the examination and/or treatment of children with ASD or a related condition, or equivalent documented coursework at the graduate level by an accredited university in the areas of ASD diagnostics, ASD developmental and behavioral treatment strategies and typical child development.

The following non-licensed practitioners are qualified to provide EIDBI treatment when services are provided for the direct benefit of the child, supervised directly and within the scope of practice of the qualified supervising professional who assumes full professional responsibility for these activities, and they are billed by a qualified supervising professional as described below:

A. **Level I EIDBI provider:**

Unless otherwise described below, all Level I providers must have at least 2,000 hours of supervised, clinical experience and/or training in the examination and/or treatment of children with ASD or a related condition, or equivalent documented coursework at the graduate level by an accredited university in the areas of ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development, or an equivalent combination of documented coursework and hours of experience.

All Level I providers must be employed by an EIDBI agency and meet at least one of the following standards:

1. Have both of the following:

a. At least 2,000 hours of supervised, clinical experience and/or training in the examination and/or treatment of children with ASD or a related condition, or equivalent documented coursework at the graduate level by an accredited university in the areas of ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development, or an equivalent combination of documented coursework and hours of experience. Providers without the required hours of supervision must receive observation and direction from a qualified supervising professional at least once per month until he or she has 2,000 hours of supervised clinical experience; and

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

~~Additionally, all Level I providers must:~~

b. ~~Have~~ A ~~a~~ master's degree, or be enrolled in a master's program, in one of the behavioral health, child development or allied fields (such as, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy) from an accredited college or university.; or ~~Providers without the required hours of supervision must receive observation and direction from a qualified supervising professional at least once per month until he or she has 2,000 hours of supervised clinical experience;~~

2. Have a bachelor's degree in one of the behavioral health, child development or allied fields (such as, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy) from an accredited college or university and advanced certification in one of the OHS recognized treatment modalities; or
3. Be a board certified behavior analyst (BCBA); or
4. Be a board certified assistant behavior analyst (BCaBA) and 4,000 hours of supervised, clinical experience that meets all registration, supervision, and continuing education requirements of the certification~~.~~; or
5. Have at least 6,000 hours of clinical experience providing early intervention services in the modality the EIDBI agency uses, and have a Bachelor's Degree in a related field, and completed the EIDBI level III provider training requirements.

B. **Level II EIDBI provider:**

All Level II providers must be employed by an EIDBI agency and meet one of the following standards:

1. Have a bachelor's degree in one of the behavioral or child development sciences or allied fields (such as, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy) from an accredited college or university; and meet one of the following requirements:

- a. have at least 1,000 hours of supervised, clinical experience and/or training in the examination and/or treatment of children with ASD or a related condition~~.~~; or
- b. equivalent documented coursework at the graduate level by an accredited university in the areas of ASD diagnostics, ASD developmental and behavioral treatment strategies and typical child development~~.~~; or
- c. an equivalent combination of documented coursework and hours of experience; or
- d. a board-certified assistant behavior analyst (BCaBA); or
- e. a registered behavior technician (RBT); or
- f. certified in one of the other treatment modalities recognized by the Department.

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

2. Be age 18 or older, have completed initial certification in the modality provided by the agency employer, have completed the EIDBI level III provider training requirements, and receive observation and direction from the advanced certification provider at least once per week until meeting 1,000 hours of supervised clinical experience; or

3. Be currently enrolled in a bachelor's degree program in one of the behavioral or child development sciences or allied fields (such as, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy) from an accredited college or university, and receive observation and direction from a qualified supervising professional or Level I treatment provider at least twice per month until meetings 1,000 hours of supervised clinical experience~~.~~; or

4. Have an associate's degree in one of the behavioral or child development sciences or allied fields (such as, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy) from an accredited college or university, and at least 2,000 hours of supervised, clinical experience in delivering treatment to children with ASD or a related condition. Hours worked as a mental health behavioral aide or Level III provider may be included in the required hours of experience~~.~~; or

5. Have at least 4,000 hours of supervised, clinical experience in delivering treatment to children with ASD or a related condition. Hours worked as a mental health behavioral aide or Level III EIDBI provider may be included in the required hours of experience~~.~~; or

6. Be a graduate student in a behavioral science, child development science, or related field, who is receiving clinical supervision from a qualified supervising professional to meet the clinical training requirements~~.~~; or

7. Be at least 18 years of age,~~—~~fluent in a language in addition to English or is an individual certified by a Tribal government, complete the Department's training requirements for a Level III provider, and receive observation and direction from a qualified supervising professional or qualified Level I provider at least once a week until reaching 1,000 hours of supervised experience.

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

C. **Level III EIDBI provider:**

All Level III providers must ~~have the following experience and or training~~ be employed by an EIDBI agency and meet the following standards:

~~a.~~ 1. Be at least 18 years old;

~~b.~~ 2. Meet the Department's specific training requirements for a Level III provider; and one of the following:

~~i.~~ a. Have a high school diploma or general equivalency diploma (GED)or~~:~~;

~~ii.~~ b. Be fluent in a language in addition to English or receive certification from a Tribal government; or

~~iii.~~ c. Have one year of experience as a primary personal care assistant, community health worker, waiver service provider, or special education assistant to a child with autism spectrum disorder or a related condition within the previous five years~~:~~.

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

Components of EIDBI services:

1. **~~Applied Behavior Analysis (ABA)~~EIDBI Interventions.** Interventions are individualized treatments based in behavioral and developmental sciences that address the child's medically necessary treatment goals. Interventions must be targeted to develop, enhance, or maintain the individual developmental skills of a child with ASD or a related condition to improve self-regulation, self-care, behavioral challenges, expressive communication, receptive communication, cognitive functioning, and safety ~~functional communication, social or interpersonal interaction, behavioral challenges and self-regulation, cognition, learning and play, self-care and safety~~.

   Qualified ~~ABA~~ providers: Qualified Supervising Professional ~~who is certified as a BCBA or BCBA-D~~, ~~ABA Developmental/Behavioral Professional (~~Level I Provider~~)~~, ~~ABA Developmental/Behavioral Practitioner (~~Level II Provider~~)~~, and ~~ABA Developmental/Behavioral Support Specialist (~~Level III Provider~~)~~.

2. ~~**Developmental and Behavioral Interventions (DBI)** are a range of individualized treatments based in developmental theory as well as behavioral sciences which are socially directed, highly engaging, and capitalize on natural motivators to strengthen primary relationships and support child development. DBI interventions focus on joint attention, social engagement and reciprocity, social and non-verbal communication, behavioral and self-regulation, cognition and play to promote development and address core functional deficits. DBI are provided as part of Department recognized single or multi-modality treatment programs.~~

   ~~Qualified providers: Qualified Supervising Professional, ABA or DBI Developmental/Behavioral Professional (Level I Provider), ABA or DBI Developmental/Behavioral Practitioner (Level II Provider), and ABA or DBI Developmental/Behavioral Support Specialist (Level III Provider).~~

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

2. **Observation and Direction** is the clinical direction and oversight by a qualified EIDBI provider to a same or lower level provider based on the required provider standards and qualifications regarding provision of EIDBI services to a child. The qualified provider delivers face-to-face observation and direction to a same or lower level provider regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for each child. This service is for the direct benefit of the child and provides a real time response to the EIDBI intervention to maximize the benefit for the child. It also informs any modifications needed to the methods to be implemented to support the accomplishment of outcomes in the Individual Treatment Plan.

   Qualified providers: Qualified Supervising Professional, Level I Provider, and Level II Provider.

3. **Family/Caregiver Training and Counseling** is specialized training and education provided, for the benefit of the child, to a family/caregiver to assist with the child's needs and development. The provider will observe, instruct and train the family/caregivers on the child's development status, and techniques and strategies to promote the child's development.

   Qualified providers: Qualified Supervising Professional, Level I Provider, and Level II Provider.

4.b. Early and periodic screening, diagnosis, and Treatment services. (continued)

4. **Coordinated Care Conference** brings together the team of professionals that work with the child and family to develop and coordinate the implementation of the individual treatment plan (ITP)to assure that services are coordinated and integrated across providers and service delivery systems. Participants in the conference will perform some, or all, of the following:
   a. Coordinate and integrate information from the CMDE process
   b. Describe intensive treatment options and expectations across service settings;
   c. Document intensive treatment scope, modality, intensity, frequency and duration based on the CMDE recommendations and family choice;
   d. Review the child's progress toward goals with the child's family;
   e. Coordinate services provided to the child and family;
   f. Identify the level and type of parent involvement in the child's intensive treatment;
   g. Coordinate program transition; and
   h. Integrate care and services across service providers to ensure access to appropriate and necessary care including medically necessary speech therapy, occupational therapy, mental health, human services or special education;

   Qualified providers: May include any of the qualified providers including ~~Must be completed by~~ the Qualified Supervising Professional (QSP), ~~and may include the~~ CMDE Provider, Level I Provider, and Level II Provider.

5. **Individual Treatment Plan (ITP)** is a person-centered, written plan of care for a child receiving EIDBI services. This includes development, ongoing monitoring, and updating of the ITP. The ITP must be based on the CMDE, be culturally and linguistically appropriate, and include input from the child's family and legal representative, who must sign in addition to the QSP. The ITP specifies the:
   - child's functional goals, including baseline measures and projected dates of accomplishment, which are developmentally appropriate, and work toward generalization across people and environments;
   - treatment modality or modalities;
   - treatment intensity, frequency and duration;
   - setting
   - discharge criteria;

4.b. Early and periodic screening, diagnosis, and Treatment services.(continued)

- Reflect the values, goals, preferences, culture and languageof the child's family.

Qualified providers: ~~Must be completed by the Qualified Supervising Professional~~ Qualified Supervising Professional, Level I Provider, and Level II Provider.

~~The child and family's primary spoken language, culture and valuesmust be considered throughout EIDBI services, including the diagnosis,CMDE, individual treatment plan development, progress monitoring, parent education and support services and coordinationof care. A language interpreter must be provided when needed.~~

EIDBI is not intended to replace services provided in school or other settings. Each child's individualized treatment plan must document that EIDBI services coordinate with, but do not include or replace special education and related services defined in the child's individualized educational plan (IEP), or individualized family service plan (IFSP), when the service is available under theIndividuals with Disabilities Education Improvement Act of 2004 (IDEA) through a local education agency. This provision does not preclude EIDBI treatment during school hours.

~~EIDBI is provided in the most integrated and inclusivesetting possible that supports, promotes, and allows:~~

- ~~inclusion and participation in the child's home and community life to the fullest extent possible as desired by and determined medically appropriate to the age, condition, and needs of the child by their legal representative in collaboration with a QSP qualified supervising professional andthrough the CMDE process;~~
- ~~opportunities for self-sufficiency, developing and maintainingsocial relationships and natural supports, and generalization of targeted skills across people and environments; and~~
- ~~a balance between risk and opportunity, meaning the least restrictive supports or interventions necessary are providedin the most integrated settings in the most inclusive manner possible.~~

EIDBI does not include services provided by a parent, legal guardian or legally responsible person.

4.c. Family Planning Services and Supplies

- Family planning services and supplies are health services or family planning supplies concerned with the voluntary planning of the conception and bearing of children and related to a recipient's condition of fertility.

- HIV blood screening testing performed as part of a package of sexually transmitted disease (STD) tests provided in conjunction with a family planning encounter is a family planning service. Counseling performed before and after the HIV blood-screening test is also a covered family planning service.

- Family planning services and supplies are covered services if the recipient requested the service, and the service is provided with the recipient's full knowledge and consent, and the provider complies with 42 CFR §441.250 to 441.259 concerning informed consent for voluntary sterilizations.

- Family planning-related services are those services provided as part of or as follow-up to a family planning visit.

- The following services are not covered:

  a) Reversal of voluntary sterilization;

  b) Hysterectomies for the purpose of sterilization;

  c) Artificial insemination;

  d) Fertility drugs when specifically used to enhance fertility; and

  e) In vitro fertilization.

5.a. Physicians' services:

- **Psychiatric services** may require prior authorization as specified in the Minnesota Health Care Program Provider Manual and on the agency's website. Coverage includes: diagnostic assessment, psychological testing, neuropsychological services, individual psychotherapy, family psychotherapy, multiple family group psychotherapy, group psychotherapy, medication management, electroconvulsive therapy single seizure, explanation of findings, unlisted psychiatric service or procedure, and biofeedback training.

- **Sterilization procedures**: Physicians must comply with all requirements of 42 CFR Part 441, Subpart F concerning informed consent for voluntary sterilization procedures.

- **Abortion services**: These services are covered: ~~when due to a physical condition, the abortion is medically necessary to prevent death of a pregnant woman, and in cases where the pregnancy is the result of rape or incest. Cases of rape and incest must be reported to legal authorities unless the treating physician documents that the woman was physically or psychologically unable to report.~~

  (1) if the pregnancy is the result of an act of rape or incest; or
  (2) in the case where a person suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the person in danger of death unless an abortion is performed.

- **Psychiatric consultations:** Consultations with psychiatrists, psychologists, licensed independent clinical social workers, licensed marriage and family therapists, and advanced practice registered nurses certified in psychiatric mental health by primary care physicians and other providers authorized to bill for physician services are covered services. If the recipient consents, consultation may occur without the recipient present. Payment for the consultation is made pursuant to Attachment 4.19-B, item 5.a.

- **Optometry services:** Physician services include services of the type which an optometrist is also legally authorized to perform and such services are reimbursed whether furnished by a physician or an optometrist.

- **Early Intensive Developmental and Behavioral Intervention (EIDBI) services:** A physician with a specialty in developmental or behavioral pediatrics and with at least 2,000 hours of experience and/or training in the examination and/or treatment of children with autism spectrum disorder (ASD) or a related condition, or equivalent documented coursework at the graduate level by an accredited university in the areas of ASD diagnostics, ASD developmental and behavioral treatment strategies and typical child development may act as the qualified supervising professional and provide EIDBI services as described in item 4.b.

5.a. Physicians' services (continued):

- **Prior Certification:** Physicians must request and obtain certification prior to admitting medical assistance recipients for inpatient hospital services, except for emergencies, delivery of a newborn, inpatient dental procedures, or inpatient hospital services for which a recipient has been approved under Medicare.

- **Delivery of services:** Physician services must be provided by or under the supervision of a medical doctor or doctor of osteopathy licensed under Minnesota Statutes, §147 and within the scope of practice defined by law. Supervised physician services are provided by enrolled physician assistants, physician extenders and community health workers providing patient education for health promotion and disease management.

- **Organ transplants:** These services are covered in accordance with the standards and statutory authority provided in Attachment 3.1-E.

- **Physical therapy, occupational therapy, and speech, language, and hearing therapy services:** Coverage of these services is limited to services within the limitations provided under items 11.a. to 11.c., Physical therapy and related services.

- **Anesthesia services:** Anesthesia services must be provided under supervision. At a minimum, physicians provide supervision. Anesthesiologists may personally perform or may medically direct (supervise) the services.

- **Physician services to pregnant women:** Physicians providing these services must be certified by the Department, through a provider agreement, as qualified to provide services to pregnant women.

- **Physician services to children under 21 years of age:** Physicians providing these services must be certified by the Department, through a provider agreement, as qualified to provide services to children under 21 years of age.

- **Pediatric vaccines:** Physicians who administer certain pediatric vaccines (i.e., vaccines that are part of the Minnesota Vaccines for Children Program) within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program. The Minnesota Vaccines for Children Program is established pursuant to §1928 of the Act.

5.a. Physicians' services (continued):

- ~~**Provider-directed care coordination**~~ **Health care home** services: Health care home ~~**provider-directed**~~ ~~care coordination~~ services are physicians' services provided in a clinical setting to recipients with complex and chronic medical conditions. All aspects of care are coordinated by the clinical staff team, which must be managed by a physician, nurse practitioner, or a physician assistant under the supervision of a physician. The team must include a dedicated care coordinator. Payment for this service ~~must be in conjunction with payment for an evaluation and management visit and is made no more frequently than once every~~ ~~six months~~ cannot be made more than once per patient per month.

  The service is comprised of the following components:

  L. Identifying recipients appropriate for health care home services ~~provider-directed~~ ~~care coordination~~ and matching intervention with need.

     1. This service is medically necessary for people with ~~five~~ one or more major chronic ~~diagnoses~~ conditions that are recurrent or persist for at least ~~one year~~ six months. Based on established methodologies, recipients with ~~chronic diagnoses~~ major chronic conditions are grouped as follows:

        - Group 1: those with ~~5-6 chronic diagnoses~~ 1-3 major chronic conditions;
        - Group 2: those with ~~7-9 chronic diagnoses~~ 4-6 major chronic conditions;
        - Group 3: those with 7-9 ~~chronic diagnoses~~ major chronic conditions:
        - Group 4: those with 10 or more ~~chronic diagnoses~~ major chronic conditions.

  M. Assessing an identified recipient's health status, risk factors, self-management skills, adherence to a treatment plan, and knowledge of and adherence to a prescribed medication regimen;

  N. Partnering with the recipient and/or family in decision-making through care team meetings with the recipient and/or family;

  O. Developing a comprehensive, individualized care plan where warranted due to patient complexity, detailing the recipient's specific medical needs and specific plans for all aspects of medical care, including preventive care, chronic care, acute care, and when appropriate, end-of-life-care and advanced

5.a. Physicians' services (continued):

directives, while incorporating social service needs and cultural preferences;

P. Documenting all levels of care provided;

Q. Coordinating care with other medical providers who are responsible for pertinent aspects of care as defined in the individual care plan;

R. Conducting periodic monitoring and evaluating a recipient's response to care provided including face-to-face contact with the primary care provider occurring at least once every six months;

S. Providing an annual comprehensive review to identify, resolve and prevent problems in utilization of care;

T. Providing available access to medical professionals with knowledge of the recipient's medical history 24 hours per day and seven days per week;

U. Assisting recipients in improving health outcomes using evidence-based guidelines and protocols;

V. Promoting behavior modification aimed at encouraging lifestyle changes to support health self-management;

Providers of health care home services ~~provider-directed care coordination~~ must be certified by the Department as having the capacity to provide the components described in items A through K, above and as qualified to engage in the following:

4. Quality improvement activities, including:

a. Participating in a quality improvement training program including ongoing training on care coordination, evidence based medicine and best practices;

b. Creating and following clinic-level, team-based internal quality improvement processes;

c. Analyzing clinic processes and patient outcome measures.

5.a. Physicians' services (continued):

d. Participating in quality improvement processes with other providers in order to develop and share best practices.

2. Create and maintain patient information in a searchable, internal clinical registry for the following purposes:
   a. Provide reminders and follow-up for comprehensive preventive care according to nationally accepted guidelines;
   b. Manage chronic illness, organize patient care and track interventions;
   c. Track patient information including diagnoses, primary language and cultural preferences and needs.
3. Designate a dedicated care coordinator to:
   a. Provide information, support and resources to ensure that the recipient adheres to therapeutic regimens;
   b. Provide information about available community and social service providers necessary for improvement and maintenance of optimal health outcomes;
   c. Provide education and training to enhance recipient understanding of and appropriate management of the recipient's condition(s). This includes education about self-management, appropriate use of resources, how to navigate the health care system, and how the primary care provider will work with the recipient to develop a plan of care where warranted due to patient complexity, in coordination with the recipient and the recipient's family and caregivers.

In-reach care coordination services:

Services by physicians include supervision of an in-reach care coordinator who documents and assesses a recipient's emergency room use, develops and implements short-term plans to reduce the recipient's too-frequent (three or more times in the previous four consecutive months) or non-urgent emergency room use, and when appropriate, develops and implements a plan to transition the recipient to a more permanent care coordination or case management relationship so that the recipient's continuum of care needs can continue to be met outside of the emergency room. Recipients may receive up to 80 hours of in-reach care coordination in a sixty day period twice per calendar year.

5.a. Physicians' services (continued):

Community Paramedic Services:

Services provided by medical directors of ambulance services include supervision of a community paramedic who provides services to recipients who have received hospital emergency department services three or more times in a period of four consecutive months in the past 12 months, or an individual who has been identified by the individual's primary health care provider for whom community paramedic services would likely prevent admission to or would allow discharge from a nursing facility or would likely prevent readmission to a hospital or nursing facility. Services provided by a community paramedic are based on a care plan created by the primary care provider (a physician, physician's assistant, or a nurse practitioner) in consultation with the medical director of the ambulance service and may include health assessments, chronic disease monitoring and education, medication compliance, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow-up care, and minor medical procedures. Services provided by the community paramedic under the care plan must be coordinated with care received by the recipient from other community providers in order to prevent duplication of services.

A community paramedic must be certified in accordance with Minnesota Statutes, section 144E.28.

Community Emergency Medical Technician Services:

Services provided by medical directors of ambulance services include supervision of a community emergency medical technician (CEMT). A CEMT may provide:

- A ~~post-hospital~~ post-discharge visit when ordered by a treating physician after discharge from a hospital or nursing facility. The ~~post-hospital~~ post-discharge visit includes:
  1) verbal or visual reminders of discharge orders;
  2) recording and reporting of vital signs to the patient's primary care provider;
  3) confirmation of access to medications;
  4) confirmation of access to food; and
  5) identification of hazards in the home.

- A safety evaluation to a recipient who has repeat ambulance calls due to falls, ~~has been discharged from a nursing home,~~ or has been identified by the recipient's primary care provider as at risk for nursing home placement. The safety evaluation includes:
  1) confirmation of access to medications;
  2) confirmation of access to food; and
  3) identification of hazards in the home.

A CEMT must be certified in accordance with Minnesota Statutes, section 144E.275, subd. 7.

5.a. Physicians' services (continued):

The services specified below are **not** covered services for purposes of medical assistance payment:

1. Surgery performed on the wrong patient;
2. Surgery performed on the wrong body part that is not consistent with the documented informed consent for that patient;
3. Performing the wrong surgical procedure on a patient that is not consistent with the documented informed consent for that patient; or
4. Physicians' services related to hospital-acquired conditions or treatment as defined in Attachment 4.19-A, Sections 2.0 and 12.3, for which hospital reimbursement is prohibited, if the physicians' services were provided by a physician who delivered care that contributed to or caused the adverse health care event or hospital-acquired condition.

5.b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act

~~Limitations to coverage are the same as those identified in item 10, Dental services.~~

6. Medical care and any other type of remedial care:

- See Items 6.a. through 6.d.

6.a. Podiatrists' services:

- Podiatry services as provided by a podiatrist within the scope of practice defined in Minnesota Statutes, chapter 153 are covered services with the following limitations:

    1) Payment for the debridement or reduction of pathological toenails and of infected or eczematized corns or calluses is limited to once every 60 days.

    2) Payment for the debridement or reduction of nonpathological toenails and of noneczematized corns or calluses is limited to the following conditions:

        A) The recipient has a diagnosis of diabetes mellitus, arteriosclerosis obliterans, Buerger's disease, chronic thrombophlebitis, or peripheral neuropathies involving the feet. The service is eligible for payment only once every 60 days unless the service is required more often to treat ulcerations or abscesses complicated by diabetes or vascular insufficiency and is medically necessary.

        B) The recipient who is not a resident of a long-term care facility has a medical condition that physically prevents him or her from reducing the nail, corn, or callus.

    3) A podiatry service provided to a recipient of a long-term care facility must result from a self referral or a referral by a registered nurse or a licensed practical nurse who is employed by the facility or the recipient's family, guardian, or attending physician.

- The following services are not eligible for payment:

    1) stock orthopedic shoes;
    2) surgical assistants;
    3) local anesthetics that are billed as a separate procedure;
    4) operating room facility charges;
    5) foot hygiene;
    6) use of skin creams to maintain skin tone;
    7) service not covered under Medicare, or service denied by Medicare as not medically necessary;
    8) debridement or reduction of the nails, corns, or calluses except as allowed above; and,
    9) general foot care that can be reasonably performed by nursing staff of long-term care facilities for recipients who reside in long-term care facilities.

6.b. Optometry~~ists'~~ services.

Vision care is described in section 5.a. of this attachment.

~~• Optometry services are covered if they are within the scope of practice for optometrists under State law or rule.~~

~~• Item 12.d. contains the list of eyeglass services that are not eligible for payment.~~

6.b. Optometrists' services. (continued.)

~~(14) Purchase of eyeglasses or lenses not covered by a contract obtained through the competitive bidding process.~~

~~(15) Backup eyeglasses.~~

~~(16) Photochromatic lenses, except for a recipient who has a diagnosis of albinism, achromatopsia, aniridia, blue cone monochromatism, cystinosis, or retinitis pigmentosa, or any other condition for which such lenses are medically necessary.~~

~~(17) Transition lenses.~~

~~(18) High index plastic lenses.~~

~~(19) Eyeglasses or lenses for occupational or educational needs, unless they is the recipient's only pair and are necessary for vision correction.~~

6.c. Chiropractors' services.

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- ~~Coverage is limited to medically necessary evaluation and manual manipulation of the spine for treatment of incomplete or partial dislocations, and the x-rays that are needed to support a diagnosis of subluxation.~~

- ~~Payment for manual manipulation of the spine of a recipient is limited to six manipulations per month and, effective January 1, 2011, twelve manipulations per year unless prior authorization for a greater number of manipulations is obtained.~~

- ~~Payment is limited to one annual evaluation unless prior authorization for additional evaluations is obtained.~~

6.d. Other practitioners' services.

B. **Mental health** services are limited to those provided by the following mental health professionals within the applicable scope of licensure:

1. licensed psychologist;
2. licensed independent clinical social worker;
3. an advanced practice registered nurse who is licensed and is certified as a clinical nurse specialist in mental health, or is certified as a nurse practitioner in pediatric or family or adult mental health nursing by a national nurse certification organization;
4. licensed marriage and family therapists. Covered Medicaid mental health services do not include marriage counseling; and
5. licensed professional clinical counselor.
6. ~~a licensed physician if the physician is: certified by the American Board of Psychiatry and Neurology, certified by the American Osteopathic Board of Neurology and Psychiatry, eligible for board certification in psychiatry.~~

Mental health services are subject to the same limitations as psychiatric services described under Item 5.a., Physicians' services.

Under the supervision of a~~n enrolled psychiatrist or other~~ mental health professional listed in this item, a clinical trainee may provide diagnostic assessment, clinical care consultation, and explanation of findings or psychotherapy. A clinical trainee may also provide psychological testing under the supervision of a licensed psychologist. A clinical trainee must:

1. have completed an accredited graduate program of study to prepare the staff person for independent licensure as a mental health professional ~~and in compliance with the requirements of the applicable health-related licensing board, including requirements for supervised practice~~; or
2. be enrolled in an accredited graduate program of study to prepare the staff person for independent licensure as a mental health professional and participating in a practicum or internship through the individual's graduate program; or
3. have completed a practicum or internship and has not yet taken or received results from required test or is waiting for the final licensure decision.

~~A clinical trainee may provide psychological testing under the supervision of a licensed psychologist.~~

~~A licensed physician assistant working in an inpatient hospital under the~~

~~supervision of a psychiatrist, or physician eligible to be licensed as a~~

~~psychiatrist,~~

~~may provide medication management and training in medication self-administration. A licensed physician assistant with 2,000 hours of clinical experience in the treatment of mental illness, and meeting the supervision requirements above, may also provide the service in an outpatient setting.~~

Services by mental health professionals include developing individual treatment plans to promote good mental health and self-management of mental health conditions, and directing and

6.d.a. Other practitioners' services, (continued)

overseeing the implementation of the individual treatment plans by community health workers.

In-reach care coordination services:
Services by mental health professionals include supervision of an in-reach care coordinator who documents and assesses a recipient's emergency room use, develops and implements short-term plans to reduce the recipient's too-frequent (three or more times in the previous four consecutive months) or non-urgent emergency room use, and when appropriate, develops and implements a plan to transition the recipient to a more permanent care coordination or case management relationship so that the recipient's continuum of care needs can continue to be met outside of the emergency room. Recipients may receive up to 80 hours of in-reach care coordination in a sixty-day period twice per calendar year.

Officer-involved, community-based care coordination:
Officer-involved, community-based care coordination diverts recipients from the criminal justice system by addressing the recipient's mental health, chemical health, social, economic, and housing needs, by connecting recipients with available covered services. The service is provided to individuals who have been involved with law enforcement, but not incarcerated, and who have screened positive for benefitting from treatment for a mental illness or substance use disorder. Recipients may receive services for up to 60 days following initiation of services. Services are provided by the following individuals who are either employed by a county or contract with a county or are an employee of or under contract with 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 to provide post-arrest officer-involved community-based care coordination and is qualified under one of the following criteria:

- A licensed mental health professional, as defined above;
- A mental health practitioner, as defined in item 13.d., working under the clinical supervision of a mental health professional; or
- A certified peer specialist, as defined in item 13.d, working under the clinical supervision of a mental health professional.
- An individual qualified as a licensed alcohol and drug counselor as defined in item 13d.; or
- A recovery peer as defined in item 13d. Working under the supervision of an individual qualified as a licensed alcohol and drug counselor.

6.d. Other practitioners' services. (continued)

B. **Public health nursing services**

Medical Assistance covers public health nursing services that are medically necessary and within the public health nurse's scope of practice. ~~are limited to~~:

Medical Assistance Covers prenatal and postnatal home visits provided in accordance with Department-approved, evidence-based treatment models. Postpartum visits can be provided up to three years after the birth of the child. The Department has approved the following models: Nurse Family Partnership, Healthy Families America, Family Spirit, and Family Connects.

~~1) Nursing assessment and diagnostic testing;~~
~~2) Health promotion and counseling;~~
~~3) Developing a care plan to promote good health and self-management of health conditions, and directing and overseeing the implementation of the care plan by a community health worker when a certified public health nurse operates under the direct authority of a city, county, tribe or school district.~~
~~4) Nursing treatment;~~
~~5) Immunization;~~
~~6) Administration of injectable medications;~~
~~7) Medication management and the direct observation of the intake of drugs prescribed to treat tuberculosis;~~
~~8) Tuberculosis case management, which means:~~
~~c) assessing an individual's need for medical services to treat tuberculosis;~~
~~f) developing a care plan that addresses the needs identified in subitem a);~~
~~g) assisting the individual in accessing medical services identified in the care plan; and~~
~~h) monitoring the individual's compliance with the care plan to ensure completion of tuberculosis therapy; and~~

Public health nurses perform ~~A~~assessments, reassessments, and service updates ~~to determine medical necessity~~ for personal care services. ~~Assessments, reassessments, and service updates~~ An initial assessment for personal care services must be conducted face-to-face~~ are conducted by county public health nurses or certified public health nurses under contract with the county~~. A face-to-face assessment is also required when there is a significant change in health status, when the recipient uses PCA Choice, and after two ~~phone~~ service update~~s~~ ~~assessments~~ have been completed by phone.

~~Assessments for personal care services must be conducted initially, in person, for people who have never had a public health nurse assessment. The initial assessment must include:~~

6.d. Other practitioners' services. (continued)

B. **Public health nursing services,** continued.

~~a) documentation of:~~
~~a. dependencies in activities of daily living;~~
~~b. presence of complex health-related needs; and~~
~~c. presence of specific behaviors including physical aggression towards self or others, or destruction of property;~~
~~b) determination of need, including meeting access criteria as described on page 78z;~~
~~c) identification of appropriate services;~~
~~d) service plan development;~~
~~e) coordination of services;~~
~~f) referrals and follow-up to appropriate payers and community resources;~~
~~g) completion of required reports;~~
~~h) if a need is determined, recommendation and receipt of service authorization; and~~
~~i) recipient education.~~

Reassessments for personal care services are conducted face-to-face, and at least annually or when there is a significant change in the recipient's condition and need for services. A service update may substitute for a reassessment as described below. ~~The reassessment includes:~~

~~a) a review of initial baseline data;~~
~~b) an evaluation of service effectiveness;~~
~~c) a redetermination of need for service;~~
~~d) a modification of the service plan, if necessary, and appropriate referrals;~~
~~e) an update of the initial forms;~~
~~f) if a need is redetermined, recommendation and receipt of service authorization; and~~
g) ~~ongoing recipient education.~~

Service updates for personal care services are conducted in lieu of an annual face-to-face ~~—~~reassessment when a recipient's condition or need for personal care assistant services has not changed substantially, or between required assessments when the recipient or provider requests a temporary increase in services until a~~n~~ face-to-face ~~in-person~~ review is conducted. The service update ~~includes all the elements listed in items a) through g), above, but~~ does not require a~~n~~ face-to-face ~~in-person~~ visit.

6.d. Other practitioners' services. (continued)

B. **Public health nursing services,** continued.

Public health nurses who administer pediatric vaccines as noted in item 5.a., Physicians' services, within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

6.d.Other practitioners' services. (continued)

C. Acupuncture Services

Effective for services delivered on or after ~~January~~ February 1, 201~~2~~6, Medical Assistance covers medically necessary acupuncture services when provided within the qualified provider's scope of practice~~coverage is limited to the treatment of chronic pain, which is pain with a documented duration of a least six consecutive months that has been unresponsive to other forms of therapy~~.

Qualified providers include licensed acupuncturists or other licensed practitioner for whom acupuncture is within the practitioner's scope of practice and who have specific acupuncture training or credentialing, including chiropractors, osteopaths and physicians.

6.d. Other practitioners' services. (continued)

D. **Certified registered nurse anesthetist (CRNA) services** may be provided by a registered nurse who is certified by the Council on Certification of the American Association of Nurse Anesthetists, or certified by the Council on the Recertification of Nurse Anesthetists of the American Association of Nurse Anesthetists, or who has graduated within the past 18 months from a nurse anesthesia program that meeting the standards of the Council on Accreditation of Nurse Anesthesia Educational Programs and is awaiting initial certification.

Coverage is limited to the following:

(1) services provided by a CRNA who is:

(a) practicing independently; ~~or~~

(b) if not practicing independently, services that are not ~~reimbursed~~ paid as part of the inpatient hospital's base rate under Attachment 4.19-A and for which the hospital has notified the Department by July 1, 1991, of ~~their~~ its intent to exclude CRNA services from ~~their~~ its charges; or

(c) practicing under the medical direction of an anesthesiologist or physician.

(2) time elapsed from the preparation of the patient for induction to the time when the CRNA is no longer in attendance.

6.d. Other practitioners' services. (continued.)

E. **Nurse practitioner services** are limited to:

(1) Services performed by ~~an adult~~ a nurse practitioner~~, obstetrical/gynecological nurse practitioner, neonatal nurse practitioner, or geriatric nurse practitioner~~ certified by the appropriate certification entity and provided within the scope of practice of the nurse practitioner's license as a registered nurse; and

(2) The types of services covered by Medical Assistance as physicians' services under item 5.a. ~~and which~~ that are within the scope of the nurse practitioner's license as a registered nurse.

Nurse practitioners who administer pediatric vaccines as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

6.d. Other practitioners' services. (continued)

F. ~~**Phlebotomy and**~~ **Case management services** provided as a component of ~~the~~ receiving ~~Clozaril patient monitoring system~~ clozapine is limited to:

~~(1) Venipuncture, which may be provided by any outpatient hospital, laboratory, or physician that meets the applicable provider requirements under Item 2.a., Outpatient hospital services, Item 3, Other laboratory and x-ray services, or Item 5.a., Physicians' services.~~

~~(2)~~ • Patient monitoring services~~, which may be~~ provided by ~~any~~ a physician, registered psychiatric nurse under the supervision of a physician, or pharmacist in an outpatient hospital, physician, clinic, or pharmacy that:

a. meets the applicable provider requirements under Item 2.a., Outpatient hospital services, Item 3, Other laboratory and x-ray services, Item 5.a., Physicians' services, or Item 12.a., Prescribed drugs; and

b. is registered with ~~Sandoz Pharmaceuticals Corporation~~ a manufacturer as clozapine as an entity eligible to participate in ~~the Clozaril Patient Monitoring System~~ a patient monitoring system.

6.d. Other practitioners' services. (continued)

G. Coverage of ~~**health maintenance**~~ **managed care organization services** provided consistent with 42 CFR Part ~~434~~ 438 and state law.

6.d. Other practitioners' services. (continued)

H. **Clinical nurse specialist** services are limited to:

1) Services performed by a nurse certified by a national nurse certification organization recognized by the Minnesota Board of Nursing. This includes certification by the American Nurses Association as a clinical specialist in psychiatric or mental health under items 5.a., Physicians' services and 6.d.A, mental health services; and

2) The types of services covered by Medical Assistance as physicians' services under item 5.a. that are within the scope of the clinical nurse specialist's license as a registered nurse.

Clinical nurse specialists who administer pediatric vaccines as noted in item 5.a., Physician's services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

6.d. Other practitioners' services. (continued)

I. Medication therapy management services

Medication therapy management services are provided by qualified, licensed pharmacists to recipients to optimize the therapeutic outcomes of a recipient's medications. It is provided to recipients taking a three or more prescription medication to treat or preventone or more chronic medical conditions.

Pharmacists must have graduated from an accredited college of pharmacyon or after May 1996, or completed a structured and comprehensive education program approved by the Minnesota Board of Pharmacy and theAmerican Council of Pharmaceutical Education.

Medication therapy management services that are otherwise covered as direct face-to-face services may be provided via telehealth. ~~two-way, interactivevideo to:~~

- ~~an ambulatory care site if the recipient is more than twenty miles from any enrolled medication therapy management provider and the interactive video site is in a trade area that does notcontain an enrolled medication therapy management provider; or~~
- ~~a recipient's home, during a covered home health care visit.~~

The service is comprised of the following components:

A. assessing a recipient's health status;
B. developing a medication treatment plan;
C. monitoring and evaluating a recipient's response to thetherapy
D. providing a comprehensive medication review to identify,resolve, and prevent medication-related problems;
E. documenting the care provided and communicating essential information to a recipient's primary care providers;
F. providing oral education and training to enhance recipientunderstanding and appropriate use of medications;
G. providing information, support services, and resources toenhance recipient adherence to therapeutic regimens;
H. coordinating and integrating medication therapy management services within the broader health care services provided to arecipient.

7. Home health services.

Covered home health services are those provided by a Medicare certified home health agency that complies with 42 CFR §§484.4 and 440.70, that are:

a) medically necessary health services;
b) ordered by a physician pursuant to a face-to-face or telemedicine encounter occurring within 90 days prior or within 30 days after the start of services;
c) documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once every 60 days; and
d) provided to the recipient in any setting in which normal life activities take place, other than ~~at his or her own place of residence that is a place other than~~ a hospital, nursing facility, or intermediate care facility for the developmentally disabled ~~mentally retarded~~ (ICF/~~MR~~DD) unless skilled nurse visits have been prior authorized for less than 90 days for a resident at an ICF/~~MR~~DD in order to prevent an admission to a hospital or nursing facility and is not required to be provided by the facility under 42 CFR Part 483, subpart I.

"Professional nurse" refers to registered nurses and licensed practical nurses, all licensed under the Minnesota Nurse Practice Act.

Home health services include the following: skilled nurse visits; home health aide visits; medical supplies, equipment and appliances; physical therapy; occupational therapy; speech pathology; and audiology.

Department authorization is required for home health aide visits or skilled nurse visits. Department authorization is based on medical necessity, physician's orders, the recipient's needs, diagnosis, and condition, the plan of care, and cost-effectiveness when compared with other care options.

7. Home health services. (continued)

The following home health services are not covered under medical assistance:

a) home health services that are the responsibility of the foster care provider;

b) home health services when not medically necessary;

c) services to other members of the recipient's household;

d) any home care service included in the daily rate of the community-based residential facility in which the recipient resides;

e) ~~nursing and rehabilitation therapy services that can reasonably be obtained as outpatient services;~~

f) ~~any home health agency service that is performed in a place other than the recipient's residence;~~

~~g)~~ more than one home health aide visit per day; and

~~h)~~ more than two skilled nurse visits per day.

Home health agencies that administer pediatric vaccines as noted in item 5.a., Physician's services within the scope if their licensure must enroll in the Minnesota Vaccines for Children Program.

Influenza and pneumococcal immunizations for adults may be administered through a standing order. The standing order includes an order from the physician, assessment criteria and contraindications for the immunizations. The professional nurse follows the standing order.

7.a Intermittent or part-time nursing services provided by a home health agency, or by a registered nurse when no home health agency exists in the area.

Covered intermittent or part-time nursing services are those provided by a Medicare-certified home health agency that are:

a) medically necessary;
b) ordered by a physician pursuant to a face-to-face or telemedicine encounter occurring within 90 days prior or within 30 days after the start of services;
c) documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once every 60 days; and
d) provided to the recipient in any setting in which normal life activities take place, other than ~~at his or her own place of residence that is a place other than~~ a hospital, nursing facility, or intermediate care facility for the developmentally disabled ~~mentally retarded~~ (ICF/~~MR~~DD) unless skilled nurse visits have been prior authorized for less than 90 days for a resident at an ICF/~~MR~~DD in order to prevent an admission to a hospital or nursing facility and is not required to be provided by the facility under 42 CFR Part 483, subpart I.

Home health agencies or registered nurses that administer pediatric vaccines as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

Influenza and pneumococcal immunizations for adults may be administered through a standing order. The standing order includes an order from the physician, assessment criteria and contraindications for the immunizations. The professional nurse follows the standing order.

7.a Intermittent or part-time nursing services provided by a home health agency, or by a registered nurse when no home health agency exists in the area. (continued)

Nurse visits are covered by medical assistance. The visits are provided in a recipient's residence, or any other setting in which that normal life activities take place, under a plan of care or services plan that specifies a level of care that the nurse is qualified to provide. These services are:

a) nursing services according to the written plan of care or services plan and accepted standards of medical and nursing practice in accordance with State laws governing nursing licensure;

b) services that, due to the recipient's medical condition, may only be safely and effectively provided by a licensed practical nurse through a home health agency or a registered nurse;

c) assessments performed only by a registered nurse; and

d) teaching and training the recipient, the recipient's family, or other caregivers.

The following services are not covered under medical assistance as intermittent or part-time nursing services:

a) nurse visits for the sole purpose of supervision of the home health aide;

b) a nursing visit that is:

i. only for the purpose of monitoring medication compliance with an established medication program; or

ii. to administer or assist with medication administration, including injections, prefilling syringes for injections, or oral medication set-up of an adult recipient, when as determined and documented by the registered nurse, the need can be met by an available pharmacy or the recipient is physically and mentally able to self-

7.a Intermittent or part-time nursing services provided by a home health agency, or by a registered nurse when no home health agency exists in the area. (continued)

administer or prefill a medication;

c) a visit made by a nurse solely to train other home health agency workers;

d) nursing services that can reasonably be obtained as outpatient services;

e) Medicare evaluation or administrative nursing visits for dually eligible recipients that do not qualify for Medicare visit billing;

f) skilled nurse visits (beyond the first nine ~~five~~ during a calendar year) that are not ~~prior~~ authorized; and

g) nursing visits when not medically necessary~~.~~;

h) homemaker services, social services, educational services, and services not prescribed by a physician.

7.b. Home health aide services provided by a home health agency.

Covered home health aide services are those provided by a Medicare-certified home health agency that are:

a) medically necessary;
b) ordered by a physician pursuant to a face-to-face or telemedicine encounter occurring within 90 days prior or within 30 days after the start of services;
c) documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once every 60 days; and
d) provided to the recipient in any setting in which normal life activities take place, ~~at the recipient's own place of residence that is a place~~ other than a hospital, nursing facility, or intermediate care facility for the developmentally disabled ~~mentally retarded~~ (ICF/DD~~MR~~).

Home health aide services must be provided under the direction of a registered nurse.

Home health aide services must be employees of a home health agency and be approved by the registered nurse to perform medically oriented tasks written in the plan of care.

Homemaker services, social services, educational services, and services not prescribed by the physician are not paid by medical assistance.

7.c. Medical supplies, equipment and appliances suitable for use in any setting in which normal life activities take place, as defined at 42 CFR § 440.70(c)(1).

Covered medical supplies, equipment and appliances suitable for use in any setting in which normal life activities take place, as defined at 42 CFR § 440.70(c)(1) are those that are:

a) medically necessary;
b) ordered by a physician, or for asthma reduction devices, ordered by a physician or other licensed practitioner acting within the scope of their license, and if required under the Medicare program, ordered pursuant to a face-to-face or telemedicine encounter with a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant, occurring within six months prior or within 30 days after the start of services;
c) documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once a year; and
d) provided to the recipient in any setting in which normal life activities take place, other than a hospital, nursing facility, or intermediate care facility for the developmentally disabled (ICF/DD).

Medical supplies and equipment ordered in writing by a physician arepaid with the following limitations:

1) A purchase of nondurable medical supplies not requiring prior authorization must not exceed an amount necessary to provide a one-month supply.

2) Maintenance or service made at routine intervals based on hours ofuse or calendar days to ensure that equipment in proper working order is payable.

3) The cost of a repair to durable medical equipment that is rented orpurchased by the Medical Assistance program under a warranty is not eligible for medical assistance payment if the repair is covered by the warranty.

4) In the case of rental equipment, the sum of rental payments during the projected period of the recipient’s use must not exceed the purchase price allowed by medical assistance unless the sum of the projected rental payments in excess of the purchase price receives prior authorization. All rental payments must apply to purchase of the equipment.

5) For individuals not receiving Medicare, the following diabetic testing supplies may only be dispensed by a pharmacy: blood glucose meters, testing strips, lancets, lancing devices, and control solutions.

Augmentative and alternative communication devices are defined as devices dedicated to transmitting or producing messages or symbols in a manner that compensates for the impairment and disability of a recipient with severe expressive communication disorders. Examples include communication picturebooks, communication charts and boards, and mechanical or electronic dedicated devices.

Asthma Reduction devices are devices proven to reduce common asthma triggers in the home of a child. Examples include HEPA filters, and mattress or pillow covers.

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7.c. Medical supplies, equipment and appliances suitable for use in any setting in which normal life activities take place, as defined at 42 CFR § 440.70(c)(1). (continued)

Prior authorization must be obtained for all augmentative and alternative communication devices.

Coverage of augmentative and alternative communication devices is limited to:

1. Evaluation for use of augmentative and alternative communication devices to supplement oral speech.
2. Speech pathologists may only provide modification and programming of augmentative and alternative communication devices.
3. Construction, programming or adaptation of augmentative and alternative communication devices.

Augmentative and alternative communication devices are not covered if facilitated communication is required in addition to the devices.

The following medical supplies and equipment are not eligible for payment:

1. Medical supplies and equipment that are. not covered under Medicare except for raised toilet seats; bathtub chairs and seats; bath lifts; prosthetic communication devices; and any item determined by prevailing community standards or customary practice ~~to be an appropriate and effective medical necessity that meets quality and timeliness standards as the most cost effective medical supply or equipment available for the medical needs of the recipient and represents an effective and appropriate use of medical assistance funds, is within the specified service limits of the Medical Assistance program, and is personally furnished by a provider.~~

2. Routine, periodic maintenance on medical equipment owned by a long-term care facility or hospital when the cost of maintenance is billed to medical assistance on a separate claim for payment.

7.d. Physical therapy, Occupational therapy or Speech pathology and Audiology services provided by a home health ~~or rehabilitation~~ agency.

Physical therapy, occupational therapy, and speech pathology and audiology services provided by a home health agency are:

a) medically necessary;
b) ordered by a physician pursuant to a face-to-face or telemedicine encounter occurring within 90 days prior or within 30 days after the start of services;
c) documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once every 60 days; and
d) provided to the recipient in any setting in which normal life activities take place, other than a hospital, nursing facility, or intermediate care facility for the developmentally disabled (ICF/DD) unless skilled nurse visits have been prior authorized for less than 90 days for a resident at an ICF/DD in order to prevent an admission to a hospital or nursing facility and is not required to be provided by the facility under 42 CFR Part 483, subpart I.

- **Covered physical therapy services** are ~~those prescribed by a physician or other licensed practitioner of the healing arts and~~ provided to a patient by a qualified physical therapist, pursuant to 42 CFR §440.110, or qualified physical therapist assistant under the direction of a qualified physical therapist.

- **Covered occupational therapy services** are ~~those prescribed by a physician or other licensed practitioner of the healing arts and~~ provided to a patient by a qualified occupational therapist, pursuant to 42 CFR §440.110, or qualified occupational therapy assistant under the direction of a qualified occupational therapist.

- **Covered speech, language, and hearing therapy services** are ~~those diagnostic, screening, preventive or corrective services~~ prescribed ~~referred by a physician or other licensed practitioner of the healing arts and~~ provided by a qualified speech pathologist~~,~~ pursuant to 42 CFR §440.110, or a qualified audiologist, pursuant to 42 CFR §440.110, in the practice of his or her profession.

- **Restorative therapy services,** as described in items 11a to 11c, are covered only when there is a medically appropriate expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time.

7.d. Physical therapy, Occupational therapy or Speech pathology and Audiology services provided by a home health ~~or rehabilitation~~ agency. (continued)

- **Specialized maintenance therapy**, as described in items 11a to 11c, is covered only when:

  - ordered by a physician~~'s or other licensed practitioner's of the healing arts~~;
  - the orders describe the ~~relate~~ necessity for specialized maintenance therapy in order to treat ~~to~~ the patient's particular medical condition(s); and

  - it is necessary for maintaining the patient's current level of functioning or for preventing deterioration of the patient's medical condition(s).

Private duty nursing services.

- Private duty nursing services are only covered when medically necessary, ordered in writing by the physician, and documented in a written plan of care that is reviewed and revised as medically necessary by the physician at least once every 62 days.
- Private duty nursing services are not reimbursable if a skilled nurse visit is appropriate, or if a personal care assistant can be utilized.
- Private duty nursing services may also be provided by a parent of a minor child, family foster parent, spouse or unpaid legal guardian, who must be a professional nurse and employed by a licensed private duty nursing agency ~~and must be included in the plan of care under direction by the physician~~.
- Private duty nursing services may be provided by a licensed registered nurse or licensed practical nurse who is the recipient's spouse, legal guardian, family foster parent or parent of a minor child, if:
  1) the nurse passes a criminal background check;
  2) the services are necessary to prevent hospitalization of the recipient; and
  3) one of the following are met:
     a the nurse resigns from a part-time or full-time job to provide nursing care for the recipient;
     b. the nurse goes from a full-time job to a part-time job with less compensation for provide nursing care for the recipient;
     c. the nurse takes a leave of absence without pay to provide nursing care for the recipient; or
     d. because of labor condition, special language needs, or intermittent hours of nursing care needed, the nurse is needed in order to provide adequate to meets the medical needs of the recipient.
  4) Authorized private duty nursing services provided by a relative, family foster parent or unpaid legal guardian may not exceed 50 percent of the total approved nursing hours, or eight hours a day, whichever is less, up to a maximum of 40 hours per week regardless of the number of children or adults who receive services.

- Private duty nursing services includes ~~-~~ongoing professional nursing services provided ~~by licensed registered nurses or licensed practical nurses employed by a home health agency or self-employed~~ when the recipient requires more individualized and continuous care than can be provided during a skilled nurse visit, by licensed registered nurses or licensed practical nurses who are self-employed or employed by a class "A" licensed home care agency, as required by state law.

- Department ~~prior~~ authorization is required for all private duty nursing services. ~~Prior a~~Authorization is based on medical necessity; physician's orders; the recipient's needs, diagnosis, and condition; an assessment of the recipient; the plan of care; and cost-effectiveness when compared to alternative care options. For recipients who meet hospital admission criteria, the Department shall not authorize more

8. Private duty nursing services. (continued)

than 16 hours per day of private duty nursing service with the following exceptions. ~~or~~ The Department may authorize up to 24 hours per day of private duty nursing service while a determination of eligibility is made for recipients who are applying for services under Minnesota's approved model home and community-based services waiver or during an appeal to the appropriate regulatory agency to determine if a health benefit plan is required to pay for medically necessary nursing services. For recipients who do not meet hospital admission criteria, the Department may authorize up to 9.75 hours per day of private duty nursing service. ~~Authorized private duty nursing services provided by a relative may not exceed 50 percent of the total approved nursing hours, or eight hours a day, whichever is less, up to a maximum of 40 hours per week.~~

Authorized units of private duty nursing service may be used in the recipient's home or outside of the recipient's home if normal life activities take the recipient outside of their home. To receive private duty nursing services at school, the recipient or his or her responsible party must provide written authorization in the recipient's care plan identifying the chosen provider and the daily amount of services to be used at school.

- Private duty nursing providers that are not Medicare certified must refer and document the referral of dual eligibles to Medicare providers when Medicare is the appropriate payer.

Recipients may receive shared private duty nursing services, defined as nursing services provided by a private duty nurse to two recipients at the same time and in the same setting at a reduced rate. Decisions on the selection of recipients to share private duty nursing services must be based on the ages of the recipients, compatibility, and coordination of their care needs.

8. Private duty nursing services. (continued)

~~that is licensed by the state, or outside the home or foster care home of one of the recipients when normal life activities, including attending school, take the recipients outside the home.~~ Shared private duty nursing services are allowed only for Medicaid recipients who would otherwise be eligible and qualified for private duty nursing services in their home or foster care home, pursuant to regulations at 42 CFR 440.80. When normal life activities, including attending school, take the Medicaid recipients sharing private duty nursing services outside the home or foster care home, they may utilize their approved hours in a child care program that is licensed by the State or operated by a local school district or private school, or an adult day care that is licensed by the State.

The provider must offer the recipient or responsible party the option of shared care. If accepted, the recipient or responsible party may withdraw participation at any time.

The private duty nursing agency must document the following in the health service record for each recipient sharing care:

a) authorization by the recipient or responsible party for the maximum number of shared care hours per week chosen by the recipient;
b) authorization by the recipient or responsible party for shared service provided outside the recipient's home;
c) authorization by the recipient or responsible party for others to receive shared care in the recipient's home;

8. Private duty nursing services. (continued)

to others in the recipient's home, or the shared care to be provided outside the recipient's home; and

e) daily documentation of the shared care provided by each private duty nurse including:

1) the names of each recipient receiving shared care together;

2) the setting for the shared care, including the starting and ending times that the recipients received shared care; and

3) notes by the private duty nurse regarding changes in the recipient's condition, problems that may arise from the sharing of care, and scheduling and care issues.

In order to receive shared care:

(a) the recipient or responsible party and the recipient's physician, in conjunction with the private duty nursing agency ~~home health care agency~~, must determine:

1) whether shared care is an appropriate option based on the individual needs and preferences of the recipient; and

2) the amount of shared care authorized as part of the overall authorization of private duty nursing services;

(b) the recipient or responsible party, in conjunction with the private duty nursing agency, must approve the setting, grouping, and arrangement of shared care based on the individual needs and preferences of the recipients;

(c) the recipient or responsible party, and the private duty nurse, must consider and document in the recipient's health service record:

1) the additional training needed by the private duty nurse to provide care to two recipients in the same setting and

8. Private duty nursing services. (continued)

to ensure that the needs of the recipients are appropriately and safely met;

2) the setting in which the shared private duty nursing care will be provided;

3) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting;

4) a contingency plan that accounts for absence of the recipient in a shared care setting due to illness or other circumstances. The private duty nurse will not be paid if the recipient is absent;

5) staffing backup contingencies in the event of employee illness or absence;

6) arrangements for additional assistance to respond to urgent or emergency care needs of recipients.

- The following services are not covered under medical assistance as private duty nursing services:

~~a)private duty nursing services provided by a licensed registered nurse or licensed practical nurse who is the recipient's spouse, legal guardian, or parent of a minor child, unless the following conditions are met:~~

~~1) the nurse passes a criminal background check;~~

~~2) the services are necessary to prevent hospitalization of the recipient; and~~

~~3) one of the following are met:~~

~~a)the nurse resigns from a part-time or full-time job to provide nursing care for the recipient;~~

~~b) the nurse goes from a full-time job to a part-time job with less compensation for provide nursing care for the recipient;~~

8. Private duty nursing services. (continued)

~~c) the nurse takes a leave of absence without pay to provide nursing care for the recipient; or~~
~~d) because of labor conditions, special language needs, or intermittent hours of nursing care needed, the nurse is needed in order to provide adequate to meets the medical needs of the recipient;~~

~~b)~~ a) private duty nursing services that are identified in the foster care placement agreement to be provided by the foster care provider who is a professional nurse as the responsibility of the foster care provider;

~~c)~~ b) private duty nursing services when other, more cost-effective, medically appropriate services are available;

~~d)~~ c) private duty nursing services provided to a resident of a hospital, nursing facility, intermediate care facility, or a licensed health care facility; and

~~e)~~ d) private duty nursing services provided by a licensed registered nurse or licensed practical nurse who is the foster care provider of a recipient who is under age 18.

State Plan under Title XIX of the Social Security Act

State/Territory: Minnesota

Section 1905(a)(9) Clinic Services

The state provides coverage for this benefit as defined at section §1905(a)(9) of the Social Security Act (the Act) and 42 C.F.R. 440.90 and as described as follows:

General Assurances

[Select all three checkboxes below.]

- ☑ The state assures services are furnished by a facility that is not part of a hospital in accordance with 42 C.F.R. 440.90.
- ☑ The state assures that services are furnished by facilities that are organized and operated to provide medical care to outpatients in accordance with 42 C.F.R. 440.90.
- ☑ The state assures that services are furnished under the direction of a physician or dentist in accordance with 42 C.F.R. 440.90(a).

Types of Clinic Services and Limitations in Amount, Duration, or Scope

[Select if applicable, describe below, and indicate if limits may be exceeded based upon state determined medical necessity criteria.]

- ☐ Limitations apply to all services within the benefit category.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(9) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #91). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Types of Clinics and Services:

[**Select all that apply and describe below as applicable**]

☐ Behavioral Health Clinics **[Describe the types of behavioral health clinics below and select below if applicable.]:**

☐ Limitations apply only to this clinic type within the benefit category. **[Describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria.]**

☑ IHS and Tribal Clinics **[Select below if applicable.]:**

☐ Limitations apply only to this clinic type within the benefit category. **[describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria].**

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☑ Renal Dialysis Clinics **[Select below if applicable.]:**

☐ Limitations apply only to this clinic type within the benefit category. **[Describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria.]**

☑ Other Clinics **[Describe the types of clinics, if any limitations apply, and select below if applicable.]:**

Ambulatory surgical center services covered under this item are facility servicesfurnished in connection with a covered surgical procedure.

☑ Limitations apply only to this clinic type within the benefit category. **[Describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria.]**

The following ambulatory surgical center services are covered:
1.Nursing services and other related services of practitioners who are involved in the recipient's health care.
2.Drugs, medical supplies, and equipment commonly furnished by the ambulatory surgical· center in connection with surgical

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procedures. Drugs are limited to those which cannot be self-administered.

3.Diagnostic or therapeutic services that are directly related to the provision of a surgical procedure.
4.Blood, blood plasma, and platelets.
5.Anesthetics and any medical supplies, whether disposable or reusable, necessary for the administration of the anesthetics.

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Section 1905(a)(9) Clinic Services

Four Walls Exceptions

The state assures that the following services may be furnished outside of the clinic. **[Select the first and second checkbox; Do not select the second checkbox if the state does not enroll IHS or Tribal facilities as providers of clinic services.]:**

☑ Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address in accordance with 42 C.F.R. 440.90(b).

☑ Services furnished outside a clinic that is a facility of the Indian Health Service, whether operated by the Indian Health Service (IHS) or by a Tribe or Tribal organization (as authorized by the Indian Self-Determination and Education Assistance Act (ISDEAA), Pub. L. 93-638), by clinic personnel under the direction of a physician in accordance with 42 C.F.R. 440.90(c).

The state elects to cover the following services outside of the clinic **[Select all that apply.]:**

☐ Services furnished outside of a clinic that is primarily organized for the care and treatment of outpatients with behavioral health disorders, including mental health and substance use disorders, by clinic personnel under the direction of a physician in accordance with 42 C.F.R. 440.90(d) **[Describe the types of behavioral health clinics such exception applies to below.]:**

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☐ Services furnished outside of a clinic that is located in a rural area and is not a rural health clinic (as referenced in section §1905(a)(2)(B) of the Act and 42 C.F.R. 440.20(b) of this subpart) by clinic personnel under the direction of a physician in accordance with 42 C.F.R. 440.90(e) **[Select one of the checkboxes below and describe the definition of a rural area that applies to this exception.]:**

☐ A definition adopted and used by a federal governmental agency for programmatic purposes **[Describe below.]:**

☐ A definition adopted by a state governmental agency with a role in setting state rural health policy **[Describe below.]:**

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(9) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #91). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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The state attests that **[Select the checkbox if the state elects to cover services outside of a clinic that is located in a rural area.]:**

☐ The selected definition of a rural area best captures the population of rural individuals that meets more of the four criteria that mirror the needs and barriers to access experienced by individuals who are unhoused:

- The population experiences high rates of behavioral health diagnoses or difficulty accessing behavioral health services;
- The population experiences issues accessing services due to lack of transportation;
- The population experiences a historical mistrust of the health care system; and
- The population experiences high rates of poor health outcomes and mortality.

Additional Benefit Description (Optional)

At its option the state may provide additional descriptive information about the benefit, beyond what is included in the federal statutory and regulatory definitions and descriptions. **[Describe below.]:**

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(9) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #91). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

10. Dental services.

A. Medically necessary dental services for children under 21 years of age are covered in accordance with EPSDT requirements as described in section 1905(r) of the Social Security Act.

B. Coverage of dental services for pregnant women is limited to medically necessary dental services as defined in 42 CFR §440.100.

C. Coverage of dental services for adults other than pregnant women is limited to the following medically necessary services:
1. Periodic oral evaluation once per calendar year
2. Limited oral evaluation
3. Comprehensive oral evaluation once every five years
4. Bite wing x-rays, one series per calendar year
5. Periapical x-rays
6. Panoramic x-rays, no more than once every five years. Panoramic x-rays may be provided more frequently when medically necessary for diagnosis and follow-up of pathology and trauma. For recipients who cannot cooperate for intraoral film due to a disability or medical condition that does not allow for intraoral film placement, panoramic x-rays are covered no more frequently than once every two years.
7. Prophylaxis, ~~four~~once per calendar year
8. Fluoride varnish, once per calendar year
9. Fillings
10. Root canals for anterior and premolar teeth
11. Full mouth debridement no more than once every five years
12. Removable partial and full dentures, one appliance per dental arch every 6 years
13. Palliative treatment and sedative fillings for relief of pain
14. Surgical services limited to:
    a. extractions
    b. biopsies
    c. incise and drain
15. Treatment for periodontal disease

~~15~~16. The following services only when provided in conjunction with dental surgery provided in an outpatient hospital setting or by a freestanding ambulatory surgical center:
   a. intraoral complete series of x-rays, once every five years
   ~~b. scaling and root planning, once every two years;~~
   ~~c~~b. general anesthesia.

~~16~~17. House calls or extended care facility calls for on-site delivery of covered services

~~17~~18. Behavioral management when additional staff time is required to accommodate behavioral challenges and sedation is not used

10. Dental services.

18. Oral or IV sedation, if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center

D. Supervised dental services are provided by enrolled community health workers educating patients to promote good oral health and self-management of dental conditions.

E. Collaborative practice dental hygienist services are provided as designated in collaborative agreements with dentists who authorize and assume full professional responsibility for the services performed. Collaborative practice dental hygienist services may be performed without the presence of a dentist and may be performed at a location other than the usual place of practice of the dentist or dental hygienist and without a dentist's diagnosis and treatment plan, unless specified in the collaborative agreement.

Collaborative practice dental hygienist services are limited to:

1. Oral health promotion and disease prevention education;
2. Removal of deposits and stains from the surfaces of teeth;
3. Application of topical preventive or prophylactic agents, including fluoride varnishes and pit and fissure sealants;
4. Polishing and smoothing restorations;
5. Removal of marginal overhangs;
6. Performance of preliminary charting;
7. Taking of radiographs; and
8. Performance of scaling and root planning.

10. Dental services. (continued)

F. Dental therapist services are provided as designated in collaborative management agreements with dentists who authorize and assume full professional responsibility for the services performed.

Dental therapist services are limited to:

3. Services performed by a dental therapist licensed by the Minnesota Board of Dentistry and provided within the scope of practice of the dental therapist's license as identified in Minnesota law; and
4. The types of dental services described in paragraphs A, B and C of this item that are within the scope of the therapist's license as a dental therapist.

G. Advanced dental therapist services are provided as designated in collaborative management agreements with dentists who authorize and assume full professional responsibility for the services performed. Advanced dental therapist services may be performed without the presence of a dentist and may be performed at a location other than the usual place of practice of the dentist or advanced dental therapist and without a dentist's diagnosis and treatment plan, unless specified in the collaborative agreement.

Advanced dental therapist services are limited to:

1. Services performed by a therapist licensed and certified by the Minnesota Board of Dentistry and provided within the scope of practice of the advanced dental therapist's license as identified in Minnesota law; and
2. The types of services described in paragraphs A, B and C of this item that are within the scope of the therapist's license as an advanced dental therapist.

10. Dental services. (continued)

H. The following dental services are not eligible for payment for any recipient:

- Pulp caps
- Local anesthetic that is used in conjunction with a dental procedure and billed as a separate procedure
- Hygiene aids, including toothbrushes
- Medication dispensed by a dentist that a recipient is able to obtain from a pharmacy
- Acid etch for a restoration that is billed as a separate procedure
- Prosthesis cleaning
- ~~Removable unilateral partial denture that is a one-piece metal including clasps and teeth~~
- ~~Replacement of a denture when a reline or rebase would correct the problem.~~
- Duplicate x-rays
- Gold restoration, inlay or onlay, including nonprecious and semiprecious metals
- Dental services for cosmetic or aesthetic purposes

I. Critical access dental providers receive an increased payment pursuant to Attachment 4.19-B, item 10. The following providers who apply are granted critical access dental provider

1. Nonprofit community clinics that meet all of the following criteria:
   a. have nonprofit status in accordance with the Minnesota revenue law;
   b. have tax exempt status in accordance with 26 U.S.C. §501(c)(3);
   c. are established to provide oral health services to low income, uninsured, special needs, and underserved individuals;
   d. have staff familiar with the cultural background of the clinic's patients;

10. Dental services. (continued)

e) have a sliding fee scale based on current federal poverty income guidelines;
f) do not restrict access or services because of a patient's financial limitations or public assistance status; and
g) have free care available as needed.

2) Public health clinics;

3) A dental clinic or group owned and operated by a nonprofit corporation with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance or MinnesotaCare;

4) Dental clinics owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system;

5) County or city owned and operated hospital-based dental clinics;

6) Hospital-based dental clinics owned and operated by an essential community provider that was formerly a state hospital, and is now an outpatient hospital specializing in the treatment of cerebral palsy, spina bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling conditions; and

7) Private practicing dentists if:
a. the dentist's office is located within the seven-county metropolitan area and more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare ~~a health professional shortage area as defined under Code of Federal Regulations, title 42, part 5, and United States Code, title 42, section 254E~~; or
b. ~~more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare; and~~
~~c)~~ the dentist's office is located outside the seven-county metropolitan area and more than 25 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare~~the level of service provided by the dentist is critical to maintaining adequate levels of patient access within the service area in which the dentist operates.~~

11.a. Physical therapy services.

Coverage is limited to:

1) Services prescribed by a physician or other licensed practitioner of the healing arts within the scope of the practitioner's practice under state law.

2) Services provided by a physical therapist or services delegated by a physical therapist to a physical therapist assistant ~~who is under the direction of a physical therapist~~.

3) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician or other licensed practitioner of the healing arts at least once every ~~60~~90 days. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or the physician's delegate as required by Medicare.

4) Services that are:

A. Restorative therapy and are provided to a recipient whose functional status is expected by the physician or other licensed practitioner of the healing arts to progress toward or achieve the objectives in the recipient's plan of care within a ~~60~~90-day period; or

B. Specialized maintenance therapy is provided only to a recipient under 21 years of age. It is provided to a recipient whose condition cannot be maintained or treated only through rehabilitative nursing services or services of other care providers, or by the recipient because the recipient's medical condition(s) result in:

i. Spasticity or severe contracture that interferes with the recipient's activities of daily living or the completion of routine nursing care, or decreased functional ability compared to the recipient's previous level of function.

ii. A chronic condition that results in physiological deterioration and that requires specialized maintenance therapy services or equipment to maintain strength, range of motion, endurance, movement patterns, activities of daily living, cardiovascular function, integumentary status, positioning necessary for completion of the recipient's activities of daily living, or decreased abilities relevant to the recipient's current environmental demands, or;

11.a. Physical therapy services. (continued)

iii. health and safety risks for the recipient.

Specialized maintenance therapy must meet at least one of the following:

i. prevents deterioration and sustains function;

ii. for a chronic or progressive medical condition, provides interventions that enable a recipient to live at his or her highest level of independence; or

iii. provides treatment interventions for a recipient who is progressing but not at a rate comparable to the expectations of rehabilitative and therapeutic care.

Physical therapist is defined as an individual who is a graduate of a program of physical therapy ~~approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent~~ accredited by the Commission on Accreditation in Physical Therapy Education or its equivalent. Physical therapists must ~~meet~~ maintain applicable state licensure ~~requirements~~, or be in compliance with state regulatory requirements in states that do not license ~~when they are developed~~. Physical therapy services and providers must meet the requirements of 42 CFR § 440.110. Physical therapy services are provided by or under the ~~direction~~ supervision of a qualified physical therapist.

Physical therapist assistant is defined as ~~one qualified under the rules of the Board of Medical Examiners. These rules define a physical therapist assistant as~~ a skilled technical worker who is a graduate of a physical therapist assistant educational program accredited by the Commission on Accreditation in Physical Therapy Education or its equivalent ~~a comparable national accrediting agency approved by the Board~~. Physical therapist assistants must maintain applicable state licensure or be in compliance with state regulatory requirements in states that do not license. A physical therapist assistant performs selected physical therapy treatments and related duties as delegated by the physical therapist to assist the physical therapist in patient, client or resident related activities.

11. a. Physical therapy services. (continued)

~~**Direction**~~ **Delegation of duties** is defined as the actions of a physical therapist who ~~instructs~~ delegates to the physical therapist assistant ~~in~~ specific duties to be performed, monitors the provision of services on-site and documents the appropriateness of the services not less than every sixth treatment session, and meets the other supervisory requirements specified in law ~~the rules of the Board of Medical Examiners~~.

Coverage does not include:

1) Services provided in a nursing facility, ICF/MR, or day training and habilitation services center, if the cost of physical therapy has been included in the facility's per diem, such as:

   A. Services for contracture that are not severe and do not interfere with the recipient's functional status or the completion of nursing care as required for licensure of the long-term care facility;

   B. Ambulation of a recipient who has an established gait pattern;

   C. Services for conditions of chronic pain that does not interfere with the recipient's functional status and that can be maintained by routine nursing measures;

   D. Services for activities of daily living when performed by the therapist, therapy assistant or therapy aide; and

   E. Bowel and bladder retraining programs.

2) Arts and crafts activities for the purposes of recreation.

11.a. Physical therapy services. (continued)

3) Services that are not documented in the recipient's health care record.

4) Services that are not designed to improve, maintain, or prevent deterioration of the functional status of a recipient with a medical condition.

5) Services by more than one provider of the same type for the same diagnosis.

6) A rehabilitative and therapeutic service that is furnished by a provider not enrolled with Medicare, or, in the case of dual eligibles, furnished by a provider who does not first bill Medicare.

7) Evaluations or reevaluations performed by a physical therapist assistant.

8) Services provided by a physical therapist other than the therapist billing for the services, unless the physical therapist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case the agency, facility or physician must bill for the service.

9) For long-term care recipients, services for which there is not a statement every 30 days in the clinical record by the therapist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

11.b. Occupational therapy services.

Coverage is limited to:

1) Services prescribed by a physician or other licensed practitioner of the healing arts within the scope of the practitioner's practice under state law.

2) Services provided by an occupational therapist or services delegated by an occupational therapist to an occupational therapy assistant ~~who is under the direction of an occupational therapist~~.

3) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician or other licensed practitioner of the healing arts at least once every ~~60~~90 days. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or the physician's delegate as required by Medicare.

4) Services that are:
   A. Restorative therapy and are provided to a recipient whose functional status is expected by the physician or other licensed practitioner of the healing arts to progress toward or achieve the objectives in the recipient's plan of care within a ~~60~~90-day period; or

   B. Specialized maintenance therapy is provided only to a recipient under 21 years of age. It is provided to a recipient whose condition cannot be maintained or treated only through rehabilitative nursing services or services of other care providers, or by the recipient because the recipient's medical conditions(s) result in:

      i. Spasticity or severe contracture that interferes with the recipient's activities of daily living or the completion of routine nursing care, or decreased functional ability compared to the recipient's previous level of function;

11.b. Occupational therapy services. (continued)

ii. A chronic condition that results in physiological deterioration and that requires specialized maintenance therapy services or equipment to maintain strength, range of motion, endurance, movement patterns, activities of daily living, cardiovascular function, integumentary status, positioning necessary for completion of the recipient's activities of daily living, or decreased abilities relevant to the recipient's current environmental demands, or;

iii. Health and safety risks for the recipient.

Specialized maintenance therapy must meet at least one of the following:

i. prevents deterioration and sustains function;
ii. for a chronic or progressive medical condition, provides interventions that enable a recipient to live at his or her highest level of independence; or
iii. provides treatment interventions for a recipient who is progressing but not at a rate comparable to the expectations of rehabilitative and therapeutic care.

Occupational therapist is defined as an individual ~~certified by the National Board for Certification in Occupational Therapy~~ who maintains applicable state licensure or is in compliance with state regulatory requirements in states that do not license~~ as an occupational therapist~~. Occupational therapy services and providers meet the requirements of ~~43~~42 CFR 440.110. Occupational therapy services are provided by or under the ~~direction~~ supervision of a qualified occupational therapist.

Occupational therapy assistant is defined as an individual ~~who has successfully completed all academic and field work requirements of an occupational therapy assistant program approved or accredited by the Accreditation Council for Occupational Therapy Education and who~~ is currently certified by the National Board for Certification in Occupational Therapy as an occupational therapy assistant. Occupational therapy assistants must maintain applicable state licensure or be in compliance with state regulatory requirements in states that do not license.

11.b. Occupational therapy services. (continued)

~~**Direction**~~ **Delegation of duties** is defined as the actions of an occupational therapist who ~~instructs~~ delegates to the occupational therapy assistant ~~in~~ specific duties to be performed, ~~and~~ monitors the provision of services, and collaborates with the occupational therapy assistant face-to-face at least every two weeks ~~on-site and documents the appropriateness of the services not less than every sixth treatment session of each recipient~~.

Coverage does not include:

1) Services provided in a nursing facility, ICF/MR, or day training and habilitation service center, if the cost of occupational therapy has been included in the facility's per diem, such as:

   A. Services for contracture that are not severe and do not interfere with the recipient's functional status or the completion of nursing care as required for licensure of the long-term care facility;

   B. Ambulation of a recipient who has an established gait pattern;

   C. Services for conditions of chronic pain that does not interfere with the recipient's functional status and that can be maintained by routine nursing measures;

   D. Services for activities of daily living when performed by the therapist, therapy assistant or therapy aide; and

   E. Bowel and bladder retraining programs.

2) Arts and crafts activities for the purpose of recreation.

3) Services that are not documented in the recipient's health care record.

11.b. Occupational therapy services. (continued)

4) Services that are not designed to improve, maintain, or prevent deterioration of the functional status of a recipient with a medical condition.

5) Services by more than one provider of the same type for the same diagnosis.

6) A rehabilitative and therapeutic service that is furnished by a provider not enrolled with Medicare, or, in the case of dual eligibles, furnished by a provider who does not first bill Medicare.

7) Evaluations or reevaluations performed by an occupational therapy assistant.

8) Services provided by an occupational therapist other than the therapist billing for the service, unless the occupational therapist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case, the agency, facility or physician must bill for the service.

9) For long-term care recipients, services for which there is not a statement every 30 days in the clinical record by the therapist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).

Coverage of **speech and language therapy services** is limited to:

1) Services provided upon written referral by a physician or licensed practitioner of the healing arts within the scope of the practitioner's practice under state law, or, in the case of a resident of a long-term care facility, on the written order of a physician as required by 42 CFR §483.45.

2) Services provided by a speech language pathologist ~~or a person completing the clinical fellowship year required for certification as a speech-language pathologist under the supervision of a speech-language pathologist~~.

3) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician or other licensed practitioner of the healing arts at least once every ~~60~~90 days. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or the physician's delegate as required by Medicare.

4) Services that are:
   A. Restorative therapy and are provided to a recipient whose functional status is expected by the physician or licensed practitioner of the healing arts to progress toward or achieve the objectives in the recipient's plan of care within a ~~60~~90-day period; or

   B. Specialized maintenance therapy is provided only to a recipient under 21 years of age. It is provided to a recipient whose condition cannot be maintained or treated only through rehabilitative nursing services or services of other care providers, or by the recipient because the recipient's medical condition(s)result in:

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).
(continued)

i. Decreased functional ability compared to the recipient's previous level of function;

ii. Decreased abilities relevant to the recipient's current environmental demands; or

iii. Health and safety risks for the recipient.

Specialized maintenance therapy must meet at least one of the following:

i. prevents deterioration and sustains function;

ii. for a chronic or progressive medical condition, provides interventions that enable a recipient to live at his or her highest level of independence; or

iii. provides treatment interventions for a recipient who is progressing but not at a rate comparable to the expectations of rehabilitative and therapeutic care.

5) For long term care recipients, services for which there is a statement in the clinical record every 30 days that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

Speech pathology services and providers meet the requirements of 42 CFR 440.110. Speech pathology services are provided by or under the supervision ~~direction~~ of a qualified speech pathologist.

11.c. Speech, language; and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

Coverage of **speech-language therapy services** does *not* include:

1) Services that are not documented in the recipient's health care record.
2) Services by more than one provider of the same type for the same diagnosis unless the service is provided by a school district as specified in the recipient's individualized education plan.
3) Services that are furnished by a provider ~~eligible to enroll with Medicare, but~~ not enrolled with Medicare, or, in the case of dual eligibles, furnished by a provider who does not first bill Medicare.
4) Services that are provided without written referral.
5) Services not medically necessary.
6) Services that are not part of the recipient's plan of care.
7) Services provided in a nursing facility, ICF/MR or day training and habilitation services center if the cost of speech-language pathology has been included in the facility's per diem.
8) Services provided by a speech-language pathologist other than the pathologist billing for the service, ~~or a person completing the clinical fellowship year under the supervision of the pathologist,~~ unless the pathologist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case, the agency, facility or physician must bill for the service.
9) ~~Services provided by an independently enrolled speech language pathologist who does not maintain an office at his or her own expense.~~
10) ~~Services provided to dual eligibles by an independently enrolled speech language pathologist.~~

Coverage of **hearing (audiology) therapy services** is limited to:

1) Services provided upon written referral by a physician or other licensed practitioner of the healing arts within the scope of the practitioner's practice under state law.

11. c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

2) Services provided by an independently enrolled audiologist who maintains an office at their own expense or an audiologist who is employed by and providing audiology services in a hospital, rehabilitation agency, home health agency, or clinic.

3) Services specified in a plan of care that is reviewed and revised as medically necessary at least once every ~~60~~90 days by the attending physician or other licensed practitioner of the healing arts. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or physician's delegate as required by Medicare.

4) Restorative therapy provided to a recipient whose functional status is expected by the physician or other licensed practitioner of the healing arts to progress toward or achieve the objectives in the recipient's plan of care within a ~~60~~90-day period.

5) For long term care recipients, services for which there is a statement in the clinical record every 30 days by the audiologist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

6) Services provided in the independent audiologist's own office, recipient's home, nursing facility, ICF/MR, or day training and habilitation services site.

Audiology services and providers meet the requirements in 42 CFR 440.110(c)(3). Audiology services are provided by or under the direction of a qualified audiologist.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

'Under the direction of a qualified audiologist' means that a federally qualified audiologist who is directing audiology services must supervise each beneficiary's care. To meet this requirement the qualified audiologist must, at a minimum, have face-to-face contact with the beneficiary initially and periodically as needed, be familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law, have continued involvement in the care provided, and review the need for continued services throughout treatment. The supervising audiologist must also assume professional responsibility for the services provided under their direction and monitor the need for continued services. The supervising audiologist must spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice. Moreover, the supervising audiologist must ensure that individuals working under their direction have contact information to permit them direct contact with the supervising audiologist as necessary during the course of treatment. In all cases, documentation must be kept supporting the supervision, provision of and claiming of services and ongoing involvement in the treatment. Absent appropriate service documentation, Medicaid payment for services may be denied providers.

Coverage of **hearing (audiology) therapy services** does *not* include:

1) Services that are not documented in the recipient's clinical record, even if the services were authorized by a physician.
2) Training or consultation provided by an audiologist to an agency, facility, or other institution.
3) Services provided by an audiologist other than the audiologist billing for the services, ~~or a person completing the clinical fellowship year under the supervision of the audiologist,~~ unless the audiologist provided the services in a hospital, rehabilitation agency, home health agency, or clinic, or as an employee of a physician or long-term care facility; in which case the contracting or employing facility, agency, or person must bill for the services.

ll.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).
(continued)

4) Services that are furnished by a provider not enrolled with Medicare, or in the case of dual eligibles, furnished by a provider who does not first bill Medicare.

Hearing aid services: After a physician rules out medical and surgical contraindictions, the physician refers the recipient for an audiologic evaluation. An audiologist or otolaryngologist provides audiologic testing, and if a hearing aid is indicated, prescribes a specific hearing aid offered under the hearing aid volume purchase contract or refers the recipient to a hearing aid services provider.

Payment is made to hearing aid services providers for hearing aids, dispensing fees, hearing aid repairs, accessories, ear molds when not provided with the hearing aid and batteries.

Coverage of **hearing aids** for adults is limited to:

1) Medically necessary ~~One~~ monaural and ~~or one set of~~ binaural hearing aids ~~within a period of five years unless prior authorized. A hearing aid will not be replaced when the recipient has received a replacement hearing aid twice within the five year period previous to the date of the request.~~

2) ~~Non-contract hearing aids require prior authorization.~~ No more than two replacement hearing aids due to loss, theft, or damage in the five years prior to the date of the request for a replacement.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

Coverage of **hearing aids** does *not* include:

1) Replacement batteries provided on a scheduled basis regardless of their actual need.
2) Services specified as part of the contract price when billed on a separate claim for payment. This includes any charges for repair of hearing aids under warranty.
3) Routine screening of individuals or groups for identification of hearing problems.
4) Separate reimbursement for postage, handling, taxes, mileage, or pick-up and delivery.
5) Nonelectronic hearing aids, telephone amplifiers, vibrating bed alarms, phone handsets, visual telephone ringers, swim molds, ear plugs, dry aid kits, and battery chargers.
6) Maintenance, cleaning; and checking of hearing aids, unless there has been a request or referral for the service by the person who owns the hearing aid, the person's family, guardian or attending physician.
7) Loaner hearing aid charges.
8) Canal type hearing aids.
9) A noncontract hearing aid that is obtained without prior authorization.
10) Services included in the dispensing fee when billed on a separate claim for payment.
11) Hearing aid services to a resident of a long-term care facility if the services did not result from a request by the resident, a referral by a registered nurse or licensed practical nurse who is employed by the long-term care facility, or referral by the resident's family, guardian or attending physician.
12) Hearing aid services prescribed or ordered by a physician if the physician or entity commits a felony listed in United States Code, title 42, section 1320a-7b, subject to the "safe harbor" exceptions listed in 42 CFR 1001.952.
~~13) Replacement of a lost, stolen or damaged hearing aid if MA has provided three hearing aids in the five years prior to the date of the request for a replacement.~~

12. Prescribed drugs, dentures, and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

See items 12.a. through 12.d.

12.a. Prescribed drugs.

The following providers are eligible for payment for dispensing prescribed drugs:

1. A pharmacy that is licensed by the Minnesota Board of Pharmacy.
2. An out of state pharmacy that complies with the licensing and certification requirements of the state in which it is located.
3. A physician located in a local trade area where there is no Medicaid enrolled pharmacy. To be eligible for payment, the physician shall personally dispense the prescribed drug according to applicable Minnesota Statutes and shall adhere to the labeling requirements of the Minnesota Board of Pharmacy.
4. A physician, physician assistant or nurse practitioner employed by or under contract with a community health board, for the purposes of communicable disease control.

The following limitations apply to pharmacy services:

1. The prescribed drug must be a drug or compounded prescription for which medical value has been established and that is made by a manufacturer that has a rebate with the Centers for Medicare & Medicaid Services (CMS) and included in the Minnesota Department of Human Services drug formulary. The formulary is established in accordance with §1927(d)(4) of the Social Security Act. See Drug Formulary.

   a) An "active pharmaceutical ingredient (API)" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing or packaging of a drug, becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredient and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:
      i. Is not a therapeutic option for the patient;
      ii. Does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and
      iii. Cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

12.a. Prescribed drugs. (continued)

2. A prescribed drug must be dispensed in the quantity specified on the prescription unless the pharmacy is using unit dose dispensing, the specified quantity is not available in the pharmacy when the prescription is dispensed, or the specified quantity exceeds a 34-day supply.

3. The dispensed quantity of a prescribed drug must not exceed a 34-day supply, unless authorized by the Department. Refill prescriptions for a 90-day supply of maintenance drugs in specific therapeutic classes identified by the Department may be dispensed without prior authorization. Contraceptive drugs may be dispensed in quantities ~~not exceeding a three-month~~ up to a 12-month supply ~~do not require~~ without prior authorization.

   Retrospective billing is a billing practice in which the pharmacy bills only for the quantity of medication actually used by the recipient during the retrospective billing cycle established by the pharmacy. A retrospective billing cycle must be between 30 and 34 days in length.

4. An initial or refill prescription for a maintenance drug shall be dispensed in not less than a 30-day supply unless the pharmacy is using unit dose dispensing, or is billing retrospectively for a quantity dispensed to a resident in a long-term care facility via unit dose or an automated dispensing system. No additional professional dispensing fee shall be paid until that quantity is used by the recipient. The pharmacy dispensing drugs to a resident in a long-term care facility must credit the state for the actual acquisition cost of all unused drugs that are eligible for reuse if the pharmacy is not using a retrospective billing process.

5. Except as provided in item (6), coverage of the professional dispensing fee for a particular pharmacy or dispensing physician for a drug for a recipient is limited to one professional dispensing fee per 30 to 34-day supply, or 90 day supply as described in #3.

6. More than one professional dispensing fee per calendar month for a maintenance drug for a recipient is allowed if:

   a) the record kept by the pharmacist or dispensing physician documents that there is a significant chance of overdose by the recipient if a larger quantity of drug is dispensed, and if the pharmacist or dispensing physician writes a statement of this reason on the prescription; or
   b) the drug is clozapine.

12.a. Prescribed drugs. (continued)

7. A pharmacy dispensing an over-the-counter drug shall receive no more than one dispensing fee per claim and the dispensing fee shall be prorated if less than the manufacturer's original package size is dispensed. A pharmacy dispensing an over-the-counter drug shall receive no more than one dispensing fee per claim if dispensing multiple packages.

8. A refill of a prescription must be authorized by the practitioner. Refilled prescriptions must be documented in the prescription file, initialed by the pharmacist who refills the prescription, and approved by the practitioner as consistent with accepted pharmacy practice under Minnesota Statutes.

9. Generic drugs must be dispensed to recipients if:

a) the generically equivalent drug is approved and is determined as therapeutically equivalent by the FDA;
b) in the pharmacist's or dispensing physician's professional judgment, the generically equivalent drug is safely interchangeable with the prescribed drug;
c) the charge for the substituted generically equivalent drug does not exceed the charge for the drug originally prescribed; and
d) the practitioner has not written in his or her own handwriting "Dispense as Written-Brand Necessary" or "DAW-Brand Necessary" on the prescription, or indicated the medical necessity of a brand name drug using an electronic prescription. Effective January 2, 2004, even if the practitioner has indicated the medical need for a brand name drug, authorization is required to dispense brand name drugs.

10. The following limits apply to legend drugs dispensed under unit dose packaging:

a) Dispensing fees for drugs dispensed in unit dose packaging shall not be paid more often than once per calendar month or when a minimum of 30 dosage units have been dispensed, whichever results in the lesser number of dispensing fees.
b) Only one dispensing fee per calendar month will be paid for each maintenance drug, regardless of the type of unit dose system used or the number of times during the month the pharmacist dispenses the drug.
c) An additional dispensing fee per prescription shall be paid to pharmacists using an in-pharmacy packaged unit dose system (except for over-the-counter medications) approved by the Board of Pharmacy for the return of drugs when dispensing to recipients in a long-term care facility if:

12.a. Prescribed drugs. (continued)

i. the pharmacy is registered with the Department by filing an addendum to the provider agreement;
ii. A minimum 30-day supply of the drug is dispensed, although a lesser quantity may be dispensed for an acute course of medication therapy for a specified time period;
iii. the national drug code from the drug stock container used to fill the unit dose package is identified to the Department;
iv. the unit dose package containing the drug meets the packaging standards set forth in Minnesota Statutes that govern the return of unused drugs to the pharmacy for reuse and documentation that unit dose packaging meets permeability standards of the Board of Pharmacy; and
v. the pharmacy provider credits the Department for the actual acquisition cost of all unused drugs that are eligible for return and reuse.

11. Delivery charges for a drug are not covered.

12. Medical assistance covers drugs purchased through the federal 340B drug pricing program by 340B covered entities and dispensed by 340B covered entities, and contract pharmacies owned by the 340B covered entity when the 340B contract pharmacy requests in writing and receives approval from the Department, to use these drugs for Minnesota Medicaid beneficiaries. Drugs acquired through the federal 340B drug pricing program and dispensed by other 340B contract pharmacies are not covered.

13. Drugs that are considered investigational, drugs that are provided to a recipient during the clinical trial designed to test the efficacy of the provided drug, or drugs that have not been approved for general use by the U.S. Food and Drug Administration are not covered. ~~The Department covers stiripentol as a specialty pharmacy product for children with certain medical conditions.~~

Drug Formulary:

All drugs and compounded prescriptions made by a manufacturer that are covered under a signed rebate agreement with CMS are included in the drug formulary, with the following limitations on coverage:

Over-the-counter drugs must be listed in the Department's "Health Care Programs Provider Manual~~,~~." ~~on a remittance~~

12.a. Prescribed drugs. (continued)

advice message, or in a Department-issued provider update. The following over-the-counter drugs are covered only when prescribed by a licensed practitioner or a licensed pharmacist who meets standards established by the Department, in consultation with the Board of Pharmacy:

a) antacids;
b) acetaminophen;
c) aspirin;
d) family planning products;
e) insulin;
f) products for the treatment of lice;
g) vitamins for adults with documented vitamin deficiencies;
h) vitamins for children under the age of seven and pregnant or nursing women; and
i) any other drug identified by the Department, in consultation with the Drug Formulary Committee.

1. The following categories of drugs are not covered pursuant to §1927(d)(2):

~~a) Drugs or active pharmaceutical ingredients used for weight loss, except that medically necessary lipase inhibitors may be covered for recipients with type 2 diabetes.~~

~~b~~a) Agents or active pharmaceutical ingredients when used to promote fertility.

~~c~~b) Agents or active pharmaceutical ingredients when used for cosmetic purposes or hair growth.

~~d~~c) Covered outpatient drugs that the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

~~e~~d) Drugs described in §107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of 21 CFR §310.6(b)(1) (DESI drugs)).

~~f~~e) Drugs or active pharmaceutical ingredients for which medical value has not been established.

12.a. Prescribed drugs. (continued)

3. The following categories of drugs are covered with limitations pursuant to §1927(d)(2):

   a) Agents when used for the symptomatic relief of cough and colds must be listed in the Department's "Minnesota Health Care Programs Provider Manual," on a remittance advice message, or in a Department-issued provider update.
   b) Prescription vitamins and mineral products for children, pregnant and nursing women, and recipients with documented vitamin deficiencies. The limitations do not apply to fluoride treatments. Prenatal vitamins are restricted to pregnant and nursing women.

~~Notwithstanding the above paragraph, some vitamins and mineral products are available for the treatment or prevention of certain diseases:~~

~~4) niacin;~~
~~5) calcium and calcium/vitamin D; and~~
~~6) generic preparations equivalent to Ocuvite.~~

4. Medicaid does not cover drugs or active pharmaceutical ingredients when used for the treatment of sexual or erectile dysfunction. Sexual or erectile dysfunction drugs and active pharmaceutical ingredients are covered when used for the treatment of other conditions or indications approved by the FDA.

5. Medicaid will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

12.a. Prescribed drugs. (continued)

Prior Authorization:

A. The following requirements, found in §1927(d)(5) of the Act, are met:
   - The prior authorization program provides a response by telephone or other telecommunication device within 24 hours of a request.
   - The prior authorization program provides for the dispensing of at least a 72-hour supply of a covered drug in an emergency situation (except for those drugs that are excluded or restricted from coverage, as noted above).

B. Prior authorization, for a period of not more than 180 days, may automatically be required for drugs approved by the FDA on or after July 1, 2005. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within Minnesota. The Department's Drug Formulary Committee will establish general authorization criteria to be used during the 180-day period.

C. Based on the requirements in §1927, the State has the following policies for the supplemental drug rebate program for Medicaid recipients:
   1. CMS has authorized the State of Minnesota to enter into the Michigan Multi-State Pooling Agreement (MMSPA) also referred to as the National Medicaid Pooling Initiative (NMPI) for drugs provided to Medicaid beneficiaries. The NMPI Supplemental Rebate Agreement (SRA) and the amendment to the SRA submitted to CMS on April 30, 2004 have been authorized for pharmaceutical manufacturers' existing agreements through their current expiration dates. The updated NMPI SRA effective for January 1, 2017, has been authorized for renewal and new agreements with pharmaceutical manufacturers for drugs provided to Medicaid beneficiaries.
   2. Supplemental drug rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national drug rebate agreement.
   3. Manufacturers with supplemental rebate agreements are allowed to audit utilization data.

12a. Prescribed drugs (continued)

4. The unit rebate amount is confidential and will not be disclosed except in accordance with §1927(b)(3)(D) of the Act.
5. A drug that the Department determines comes within its multi-state supplemental drug rebate program for Medicaid recipients as allowed by §1927, but for which a manufacturer has not signed a supplemental drug rebate agreement authorized by CMS, will be prior authorized.

   Even if a manufacturer has not signed a supplemental drug rebate agreement, there is never prior authorization for any atypical antipsychotic drug prescribed for the treatment of adult mental illness if:
   - there is no generically equivalent drug available; and
   - the drug was initially prescribed for the recipient before July 1, 2003; or
   - the drug is part of the recipient's current course of treatment.

Medicaid covers the following prescribed drugs not eligible for rebate:

- vitamins for adults with documented vitamin deficiencies
- vitamins for children under the age of seven and pregnant or nursing women

The State may enter into value-based contracts with manufacturers on a voluntary basis. These contracts will be executed on the model agreement entitled "Value-Based Supplemental Rebate Agreement" authorized for use beginning April 1, 2024.

12.b. Dentures.

A Removable unilateral partial denture that is a one-piece metal including clasps and teeth is not eligible for payment for any recipient.

Medically necessary denture services for children under 21 years of age are covered in accordance with EPSDT requirements as described in section 1905(r) of the Social Security Act.

The reline or rebase of a removal denture is covered for all recipients.

For pregnant women:

- Initial placement or replacement of removable dentures is limited to one time every three years for a recipient unless the dentures are misplaced, stolen or damaged due to circumstances beyond the recipient's control, or the dentures cannot be modified or altered to meet the client's dental needs.

- ~~Replacement of dentures less than three years old requires prior authorization.~~

- The payment rate for dentures includes instruction for the use and care of the dentures and any adjustment necessary during the first six months immediately following the provision of the dentures.

- Coverage does not include denture replacement if a reline, rebase or repair would correct the problem.

For adults other than pregnant women:

- ~~Removable partial and full dentures are limited to one appliance per dental arch every six years.~~
- Initial placement or replacement of removable dentures is limited to one time every six years for a recipient unless the dentures are misplaced, stolen or damaged due to circumstances beyond the recipient's control, or the dentures cannot be modified or altered to meet the client's dental needs.

- The payment rate for dentures includes ~~payment for~~ instruction for ~~on~~ the use and care of the dentures and any adjustment necessary during the first six months immediately following the provision of the dentures.

- Coverage does not include denture replacement if a reline, rebase or repair would correct the problem.

12.c. Prosthetic devices.

- Prosthetic or orthotic devices means replacement, corrective or supportive devices for the purpose of artificially replacing a missing portion of the body or to prevent or correct physical deformity or real function or to support a weak or deformed part of the body.

- Prosthetic or orthotic devices are eligible for payment with the following limitation:

  - Ambulatory aid must be prescribed by a physician who is knowledgeable in orthopedic or physiatrics, or by a physician in consultation with an orthopedist, physiatrist, physical therapist, or occupational therapist, or by a podiatrist.

- The following prosthetic or orthotic devices and repairs are not eligible for payment:

  1) A device for which Medicare has denied the claim as not medically necessary;
  2) A device that is not medically necessary for the recipient;
  3) A device, other than a hearing aid, that is provided to a recipient who is an outpatient or resident of a long-term care facility and this is billed directly to medical assistance except as in item 7.c., Medical Supplies, Equipment and Appliances;
  4) Repair of a rented device;
  5) Repair of a device if the repair is covered by warranty;
  6) Routine, periodic service of a recipient's device owned by a long-term care facility;
  7) A device that has as a purpose to serve as a convenience to a person caring for the recipient;
  8) A device that is not received by the recipient;
  9) A device that serves to address social and environmental factors and that does not directly address the recipient's physical or mental health; and
  10) A device not supplied by a medical supplier.

12.d. Eyeglasses.

- Comprehensive vision examinations and intermediate vision examinations are eligible for payment.

- Medically necessary eyeglasses are specifically defined.

- Eyeglasses which have been lost, stolen, or irreparably damaged must be an identical replacement.

- Payment will be made for a new pair of eyeglasses for:

  1) A change in the recipient's head size.
  2) A change in eyeglasses that are medically necessary ~~mandated by medical necessity~~.
  3) An allergic reaction to the eyeglass material.
  4) A prescription change of .5 diopter or greater.

- The following eyeglasses or ~~eyeglass~~ vision services are not covered:

  1) Cosmetic services.
  2) Contact lenses prescribed for reasons other than aphakia, keratoconus, aniseikonia, marked acuity improvement over correction with eyeglasses, or bandage lenses.
  3) Dispensing services related to a noncovered service.
  4) Replacement of lenses or frames to change the style or color.
  5) Fashion tints and polarized lenses, unless medically necessary.
  6) Protective coating for plastic lenses.
  7) Edge and anti-reflective coating of lenses.
  8) Industrial or sport eyeglasses, unless they are the recipient's only pair and are necessary for vision correction.
  9) Eyeglasses, lenses, or frames that are not medically necessary.
  10) Invisible bifocals or progressive bifocals.

12.d. Eyeglasses. (continued)

11) An eyeglass service for which a required prior authorization was not obtained.

12) Replacement of lenses or frames due to provider error in prescribing, frame selection, or measurement. The provider making the error is responsible for bearing the cost of correcting the error.

13) Services or materials that are considered to be experimental or nonclinically proven by prevailing community standards or customary practice.

14) Eyeglass repair during the warranty period if the repair is covered by warranty.

15) Backup eyeglasses.

16) Photochromatic lenses, except for a recipient who has a diagnosis of albinism, achromatopsia, aniridia, blue cone monochromastism, cyctinosis, or retinitis pigmentosa, or any other condition for which such lenses are medically necessary.

17) ~~Transition lenses unless medically necessary.~~

~~18)~~ ~~High index plastic lenses~~.

~~19)~~ Eyeglasses or lenses for occupational or educational needs, unless it is the recipient's only pair and are necessary for vision correction.

18. Purchase of eyeglass frames or lenses not covered by a contract obtained through the competitive bidding process.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

See items 13.a. through 13.d.

13.a. Diagnostic services.

- Must be medically necessary, the least expensive, appropriate alternative, and delivered by an enrolled MA provider.

13.b. Screening services.

- Must be medically necessary, the least expensive, appropriate alternative, and delivered by an enrolled MA provider.

13.c. Preventive services.

- Preventive services are health services provided to a recipient to avoid or minimize the occurrence or recurrence of illness, infection, disability, or to provide care for pregnancy.

- Services must be provided to the recipient on a face-to-face basis.

- The services must affect the recipient's care rather than the recipient's environment.

- The service must not be otherwise available to the recipient without cost as part of another program funded by a government or private agency.

- The service must not be part of another covered service.

- The service must be to avoid or minimize an illness, infection, or disability which will respond to treatment.

- The service must be generally accepted by the provider's professional peer group as a safe and effective means to avoid or minimize the illness, infection, or disability.

- Prior authorized cardiac rehabilitation services are covered preventive services with the following limitations:

  1) The services must be defined services whereby a physician is on the premises of the active program at all times in which the facility is opened.

  2) The services must be conducted in an area set aside for the exclusive use of the program while it is in session.

  3) The service must be a Medicare approved cardiac rehabilitation program.

13.c. Preventive services. (continued)

- The following services may be offered within the cardiac program as a covered service:

  1) diagnostic testing - stress testing;

  2) ECG monitoring;

  3) other reasonable and necessary diagnostic services;

  4) psychotherapy,

  5) exercise therapy.

- The following cardiac rehabilitation services are not eligible for payment:

  1) services provided without the direct on premises supervision of a physician;

  2) physical therapy and occupational therapy in connection with a cardiac rehabilitation program unless there is also a diagnosis of a non-cardiac condition requiring such therapy;

  3) patient education.

- The following preventative services are not eligible for payment:

  1) service that is only for a vocational purpose or an educational purpose that is not health related; and

  2) service dealing with external, social, or environmental factors that do not directly address the recipient's physical or mental health.

13.c. Preventive services. (continued)

The following are preventive services covered without cost-sharing:

Any clinical preventive services that currently have a rating of A or B from the United States Preventive Services Task Force (USPSTF.

Approved immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention, and their administration.

Changes to ACIP recommendations are incorporated into coverage and billing codes as necessary to comply with revisions.

13.d. Rehabilitative Services

Rehabilitative services are limited to:

(3) Except as otherwise noted, services provided under the recommendation of a physician. The therapeutic treatment must be a part of the recipient's plan of care; and
(4) Services that are medically necessary and the least expensive, appropriate alternative.

Mental health rehabilitative services are the following:

- Community mental health center (CMHC) services provided by a facility that meets the requirements of applicable state law. ~~Minnesota Statutes §256B.0625, subdivision 5~~

- The CMHC must be ~~licensed~~ certified as a mental health clinic under applicable state law ~~Minnesota Rules, parts 9520.0750 to 9520.0870~~. The CMHC must ~~to~~ provide mental health services under the ~~clinical supervision~~ oversight of a mental health professional who is ~~licensed for independent practice at thedoctoral level, or a psychiatrist who is eligible for board certification~~a doctoral level psychologist or a board certified or board eligible psychiatrist. ~~A CMHC's mental health team includes at least a:~~

~~4. Licensed physician who has completed an approved residency program in psychiatry;~~

~~5. doctoral clinical, counseling, or health care psychologist; and~~

~~6. clinical social worker with a master's degree in social work from an accredited college or university and/or a clinical psychiatric nurse with a master's degree in psychiatric nursing or a related psychiatric nursing program from an accredited college or university.~~

A CMHC's mental health team must include mental health professionals as described in item 6.D.A. A CMHC's mental health team may include clinical trainees as described in item 6.D.A as well as ~~As needed, the mental health team may also consist of~~ other professionals, paraprofessionals and disciplines. Staff qualifications are consistent with the specific service listed, below.

CMHC services are furnished by a private nonprofit corporation or a governmental agency that has a

13.d. Rehabilitative services. (continued)

community board of directors. Providers must be capable of providing the services to recipients who are diagnosed with both mental illness or emotional disturbance and chemical dependency, and to recipients dually diagnosed with a mental illness or emotional disturbance and developmental disability.

The following are included in the **CMHC services** payment:

8. Diagnostic assessment
9. Explanation of findings
10. Family, group and individual psychotherapy, including crisis interventionpsychotherapy services, multiple family group psychotherapy, psychologicaltesting, and medication management
11. Adult day treatment services provided as described below.
12. Professional home-based mental health services
13. For Medicare-certified centers, partial hospitalization formental illness, as defined at §1861(ff) of the Act
14. Neuropsychological services provided as described below.

Adult day treatment includes at least one hour of group psychotherapy and must include group time focused on rehabilitative interventions or other therapeutic services that are provided by a multidisciplinary staff. Rehabilitative interventions are linked to goals and objectives identified in an individual's treatment plan which will lead to improvement in functioning that has been impaired by the symptoms of individual's mental illness or emotional disturbance. Other therapeutic services may include such services as harm reduction or cognitive behavior therapy. Coverage is limited to services provided up to 15 hours per week.

Individual members of the adult day treatment multidisciplinary team must meet, at a minimum, the standards for a mental health practitioner that apply to adult rehabilitative mental health services as defined in this item. Members of the multidisciplinary team provide only those day treatmentservices that are within their scope of practice.

The following agencies may apply to become adult day treatmentproviders:

- Licensed outpatient hospitals with JCAHO accreditation;
- MHCP-enrolled community mental health centers; or
- Entities under contract with a county to operate a day treatment program.

Neuropsychological services include neuropsychological assessment and neuropsychological testing.

13.d. Rehabilitative services. (continued)

Eligible providers of clinical neuropsychological services must meet one of the following:

- Have a diploma from one of the following:
  - American Board of Clinical Neuropsychology (ABCN)
  - American Board of Professional Neuropsychology (ABPN)
  - American Board of Pediatric Neuropsychology (ABPdN)

- Have been enrolled as an eligible provider of neuropsychological assessment prior to December 31, 2010;

- Earned a doctoral degree in psychology from an accredited university training program:
  1. completed an internship, or its equivalent, in a clinically relevant area of professional psychology;
  2. completed the equivalent of two full-time years of experience and specialized training, at least one which is at the postdoctoral level, in the study and practices of clinical neuropsychology and related neurosciences supervised by a clinical neuropsychologist or
  3. have been credentialed by another state's board of psychology examiners in the specialty of clinical neuropsychology utilizing equivalent requirements to those specified by one of the above-named Boards.

~~Telemedicine services. CMHC services,~~ ~~except adult day treatment services and partial hospitalization for mental illness, that are otherwise covered as direct face-to-face services may be provided via two-way, interactive video if medically appropriate to the condition and needs of the recipient.~~

The community mental health center must provide 24-hour emergency care or demonstrate the capacity to assist recipients in need of such services on a 24-hour basis.

13.d. Rehabilitative services. (continued)

- **Community health worker services** are recommended by a mental health professional defined in item 6.d.A. after a diagnostic assessment. They provide culturally relevant patient education and care coordination services pursuant to an individual treatment plan, written by a mental health professional or by a mental health practitioner or clinical trainee under the supervision of a mental health professional.

- **Adult rehabilitative mental health services (ARMHS)** are recommended by a mental health professional ~~defined in item 6.d.A.~~ after a diagnostic assessment and a functional assessment. They are provided pursuant to an individual treatment plan, written by a mental health professional or by a clinical trainee or mental health practitioner under the ~~clinical~~ supervision of a mental health professional. The services are provided on a one-to-one basis or in a group in arecipient's home, a relative's home, school, place of employment, or other community setting.

Adult rehabilitative mental health services are provided by:

1. A county-operated or non-county operated entity certified by the Department.

2. A facility of the Indian Health Service or a facility owned or operated by a tribe or tribal organization and funded by either Title I of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, or Title I of the Indian Self Determination and Education Assistance Act, P.L. 106-260, operating as a 638 facility.

13.d. Rehabilitative services. (continued)

Provider Qualifications, Supervision and Training

2. A mental health practitioner must be qualified in at least one ofthe following ways:

A. has completed coursework in of thebehavioral sciences or related fields equal to 30 semester hours or 45 hours under a quarterssystem, and one of the following:

(i) has at least 2,000 hours of supervised experience in the delivery of services to:

1) persons with mental illness, emotional disturbance, or substance use disorder; or

2) persons with traumatic brain injury or developmental disabilities, and completes Department required training on mental illness;

(ii) is fluent in the non-English language of the ethnic group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to persons with mental illness or emotional disturbance, and receives ~~clinical~~ supervision from a mental health professional at least once a week until the requirement of 2,000 hours of supervised experience is met;

(iii) works in a day treatment program; or

(iv) has completed a practicum or internship that required direct interaction with clients and was focused on behavioral sciences or a related field.

B. has at least 4,000 hours of supervised experience in the delivery of services to persons with mental illness, emotional disturbance, or substance use disorder; a practitioner with 2,000 hours of supervised experience must receive weekly supervision from a mental health professional until he or she has 4,000 hours of supervised experience;

C. has at least 4,000 hours of supervised experience in the delivery of services to clients with traumatic brain injury or developmental disabilities, and completes Department required training on mental illness. A practitioner with 2,000 hours of supervised experience must receive weekly supervision from a mental health professional until he or she has 4,000 hours of supervised experience;

D. is a graduate or undergraduate student in one of the behavioral sciences or relatedfields and is formally assigned by an accredited college or university to an agency or facility for clinical training;

13.d Rehabilitative services. (continued)

E. holds a master's or other graduate degree in one of the behavioral sciences or related fields from an accredited college or university;

F. holds a bachelor's degree in one of the behavioral sciences or related fields, and completes a practicum or internship that requires direct interaction with clients and is focused on behavioral sciences or a related field; or

~~G. is working as a clinical trainee as described in item 6.d.A.~~

A mental health practitioner must receive ongoing continuing education training ~~as required by the practitioner's professional license; or, if not licensed, a mental health practitioner must receive ongoing continuing education training~~ of at least 30 hours every two years in areas of mental illness and mental health services.

3. A mental health rehabilitation worker must:

A. Be at least ~~21~~18 years of age;

B. Have a high school diploma or equivalent;

C. Have successfully completed 30 hours of training before provision of direct services, or during the two years immediately prior to the date of hire, in all the following areas: recovery from mental illness/emotional disturbance, mental health de-escalation techniques, recipient rights, recipient-centered individual treatment planning, behavioral terminology, mental illness/emotional disturbance, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, and recipient confidentiality; and

D. Meet the qualifications in (1), (2) or (3)below:

(1)

(a) have an associate of arts degree; ~~or~~

(b) completed a two-year full-time, post-secondary education in one of the behavioral sciences or human services;

(c) completed coursework in one of the behavioral sciences or related fields equal to 15 semester hours or 23 hours under a quarters system;

(d) be a registered nurse ~~or~~

(e) within the previous ten years:

(i) have three years of personal life experience with serious mental illness;

(ii) have three years of life experience as a primary caregiver to a person with a serious mental illness/emotionaldisturbance, substance use disorder, developmental disability, or traumatic brain injury; or

(iii) have 2,000 hours of supervised work experience in the delivery of mental health services topersons with serious mental illness/emotional disturbance, substance use disorder, developmental disability, or traumatic brain injury; or

13.d. Rehabilitative services. (continued)

(4) (a) Be fluent in the language or competent in the cultureof the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong;

(f) receive monthly individual ~~clinical~~ supervision by amental health professional during the first 2,000 hours ofwork. Supervision must be documented;

(g) receive direct observation by a mental health professional, clinical trainee, or mental health practitioner twice per month for the first six months of employment and once per month thereafter. ~~have 18 hours of documented field supervision by a mental health professional or mental health practitioner during the first 160 hours of contact work with recipientsand at least six hours of field supervision quarterly during the following year~~;

(h) have review and ~~cosignature of charting of recipient contacts~~ approval of progress notes made for services during ~~field supervision~~ direct observation by a mental health professional, clinical trainee or mental health practitioner; and

~~(i) have 15 hours of additional continuing education onmental health topics during the first year of employmentand 15 hours during every additional year of employment.~~Or,

~~(5) For providers of intensive residential treatment services or crisis stabilization services in a residential setting, meet the qualifications described below:~~

~~(a) Meet the requirements of clause 2(b) - (d) above; and~~

~~(b) Have 40 hours of additional continuing education on mental health topics during the first year of employment;~~

~~E. Receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness/emotional disturbanceand mental health services and other areas specific to the population being served.~~

13.d. Rehabilitative services. (continued)

4. **Certified Peer Specialist**:

A. **Certified Peer Specialist Level I** must:

1. Be at least ~~21~~ 18 years of age;
2. ~~Have a high school diploma or equivalent;~~
3. Have had a primary diagnosis of mental illness;
4. Be a current or former consumer of mental health services;
5. Successfully complete peer specialist certification training,approved by the Department of Human Services that teaches specific skills relevant to providing peer support to other consumers.

B. **Certified Peer Specialist Level II** must:

1. Meet all of the qualifications of a Certified Peer SpecialistLevel I and;
2. Meet one of more of the following:
   a. Be qualified at the Mental Health Practitioner level asdefined in section 4.b;
   b. Have at least 6,000 hours of supervised experience inthe delivery of peer services to persons with mental illness;
   c. Have at least 4,000 hours of supervised experience in thedelivery of services to persons with mental illness and an additional 2,000 hours of supervised experience in the delivery of peer services to persons with mental illness.

~~C. **Certified Peer Specialists Level I and II** must:~~

~~1. Receive documented monthly individual clinical supervision bya mental health professional during the first 2,000 hours of work;~~
~~2. Have 18 hours of documented field supervision by a mental health professional or mental health practitioner during the first 160 hours of contact work with recipients and at least six hours of field supervision quarterly during the followingyear;~~
~~3. Have review and co-signature of charting of recipient contactsduring field supervision by a mental health professional or mental health practitioner; and~~
~~4. Complete continuing education training of at least 30 hours every two years in areas of recovery, rehabilitative servicesand peer support.~~

13.d. Rehabilitative services. (continued)

5. A clinical trainee is defined according to 6.d.A

For the purposes of adult rehabilitative mental health services, a mental health professional is defined in item 6.d.A. Except for the provision of diagnostic assessments, a mental health professional also includes a nationally certified provider who has:

(1) a master's degree from an accredited college or university in behavioral sciences or related fields;

(2) at least 4,000 hours of post-master's supervised experience providing mental health services to clients; and

(3) a valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner.

A clinical trainee, mental health practitioner, certified peer specialist, or mental heath rehabilitation worker must have at least 30 hours of continuing education every two years, as described by state law.

A clinical trainee, mental health practitioner, certified peer specialist, or mental heath rehabilitation worker must perform all services described under the supervision of a mental health professional and have a written treatment supervision plan, developed within 30 days of employment and updated annually.

~~Each staff person's treatment supervision plan must include:~~

~~(1) the name and qualifications of the staff person receiving treatment supervision;~~

~~(2) the names and licensures of the treatment supervisors who are supervising the staff person;~~

~~(3) how frequently the treatment supervisors must provide treatment supervision to the staff person; and~~

~~(4) the staff person's authorized scope of practice, including a description of the client population that the staff person serves, and a description of the treatment methods and modalities that the staff person may use to provide services to clients.~~

6. An Occupational Therapist, as described in item 11.b.

13.d. Rehabilitative services. (continued)

~~**Components of Mental Health Community Support Services**~~
Adult rehabilitative mental health services (ARMHS) are comprised of the following six component services. ~~A mental health professional, a mental health practitioner under the clinical supervision of a mental health professional,~~ and a certified peer specialist II ~~under the clinical supervision of a mental health professional are qualified to provide components 1 - 5. A a mental health rehabilitation worker under the direction of a mental health professional, or a mental health practitioner and under the clinical supervision of a mental health professional must be capable of providing the following three components~~ is qualified to provide components 3 - 5. ~~A certified peer support specialist I under the clinical supervision of a mental health professional is qualified to provide peer support (component 5) services only.~~

~~A mental health professional means an individual defined in item 6.d.B. or an individual who: 1) has a master's degree from an accredited college or university in one of the behavioral sciences orrelated fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness; and 2) holds a current and valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner.~~

The qualifications for a clinical trainee, mental health practitioner, a certified peer specialist, and a mental health rehab worker are previously describedin this item.

3. Functional assessment: A functional assessment is provided by a mental health professional, clinical trainee, or mental health practitioner. A complete **functional assessment** consists ofthe following two component:
   a. The **assessment of functional ability** is a narrative that identifies and describes:
      - the person's functional strengths and deficits;
      - the person's current status within each life area domain; and
      - the linkage between the individual's mental illness and their status and level of functioning within each life area domain.
   b. The assessment of functional ability informs the **level of care assessment,** which determines the service intensity needs of the individual.

4. Individualized treatment plan: An individualized treatment plan is provided by a mental health professional, clinical trainee, or mental health practitioner. A treatment plan is based on a diagnostic and functional assessment, documents the plan of care and guides treatment interventions. Development of the treatment plan includes involvement of the client, client's family, caregivers, or other persons, which may include persons authorized to consent to mental health services for the client, and includes arrangement of treatment and support activities consistent with the client's cultural and linguistic needs.

13.d. Rehabilitative services. (continued)

5. Basic living and social skills are provided by any of the staff types listed above, ~~which~~ and may include:
   a. Communication skills.
   b. Social skills
   c. Budgeting and shopping skills.
   d. Healthy lifestyle skills.
   e. Household management skills.
   f. Transportation skills.
   g. Medication monitoring.
   h. Crisis assistance skills, including relapse prevention skills ~~.~~

6. Community intervention is provided by any of the staff types listed above, and is the consultation with relatives, guardians, friends, employers, treatment providers, and other significant people. Community intervention enables the recipient to retain stability, function in the community, and reduces the risk of significant decompensation or theneed to move to a more restrictive setting. The intervention must be directed exclusively to the treatment of the recipient.

7. Certified Peer Specialist support is provided by a certified peer specialist I or II, ~~which~~ and must include:
   a. Non-clinical peer support that is person-centered and recovery-focused;
   b. Promoting recipient ownership of the plan of care to ensure the plan reflects the needs and preferences of the recipient in achieving specific, measurable results;
   c. Assisting the recipient with specific, recovery-focused activities designed to promote empowerment, self-determination and decision-making to help the recipient achieve personal wellness and cope with the stressors and barriers encountered when recovering from their disability;
   d. Participating as a fully integrated mental health team member who provides highly individualized services in the community and shares the experience of mental health consumers and consumer culture to inform the team.
   e. Providing a level of Certified Peer Specialist support determined on an individual basis taking into account the intensity of the situation, the knowledge base of the Certified Peer Specialist and the acuity of the beneficiary’s condition.

13.d. Rehabilitative services. (continued)

8. ~~A~~ Medication education is provided by a physician, physician assistant, pharmacist ~~and~~ or registered nurse~~ must be capable of providing medication education~~. Medication education includes training the recipient in the symptoms of mentalillness, discussing the benefits and side effects of psychotropic medication, and discussing the importance of medication compliance.Medical education enables the recipient to better manage the symptoms of mental illness, allowing the recipient to return to independent functioning with less chance of relapse.

The services below are not eligible for medical assistance payment as adult rehabilitative mental health services:

10. Recipient transportation services.
11. Services billed by a nonenrolled Medicaid provider.
12. Services provided by volunteers.
13. Direct billing of time spent "on call" when not providingservices.
14. Job-specific skills services, such as on-the-job training.
15. Performance of household tasks, chores, or related activities forthe recipient.
16. Provider service time paid as part of case management services
17. Outreach services, which means services identifying potentially eligible people in the community, informing potentially eligiblepeople of the availability of adult rehabilitative mental health services, and assisting potentially eligible people with applying for these services.
18. Services provided by a hospital, board and lodge facility, orresidential facility to patients or residents. This includes services provided by an institution for mental disease.

13.d. Rehabilitative services. (continued)

Mental health crisis response services are services recommended by a physician, mental health professional defined in item 6.d.A, or licensed mental health practitioner. Mental health crisis response services may be provided by the following provider types:

1. A county-operated or non-county operated entity certified by the Department.
2. A facility of the Indian Health Service or a facility owned or operated by a tribe or tribal organization and funded by either Title I of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, P.L. 106-260, operating as a 638 facility.

Mental health crisis team members must meet the qualifications, training and supervision standards that apply to adult rehabilitative mental health services in addition to completing at least 30 hours of training in crisis response services skills and knowledge every two years. Members of the team provide only those crisis services that are within their scope of practice, and under the supervision required by state law.

The components of mental health crisis response services are:

3. **Crisis assessment.** Crisis assessment is an immediate face-to-face appraisal by a physician, mental health professional, clinical trainee, or mental health practitioner ~~under the clinical supervision of a mental health professional~~, following a determination that suggests therecipient may be experiencing a mental health crisis.

   The crisis assessment is an evaluation of any immediate needs for which emergency services are necessary and, as time permits, the recipient's life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning.

4. **Crisis intervention.** Crisis intervention is a face-to-face, short-term intensive service provided during a mental health crisis to help a recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning. Crisis intervention must be available 24 hours a day, seven days a week. However, if a county provider demonstrates to the satisfaction of the Department that, due to geographic or other barriers, it cannot provide crisis intervention 24 hours a day, seven days a week, the Department may approve a county provider based on an alternative plan proposed by a county or group of counties. The alternative plan must be designed to:

1) result in increased access and reduction in disparities in the availability of crisis services;

13.d. Rehabilitative services. (continued)

and 2) provide mobile services outside of normal business hours and on weekends and holidays.

A. Crisis intervention is provided after the crisis assessment.

B. Crisis intervention includes developing a crisis treatment plan. The plan must include recommendations for any needed crisis stabilization services. It must be developed no later than 24 hours after the first face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided. The plan must be updated as needed to reflect current goals and services.

The crisis intervention team must document which short-term goals were met, and when no further crisis intervention services are required.

C. The crisis intervention team is comprised of at least two mental health professionals, or a combination of at least one mental health professional and one mental health practitioner or clinical trainee with the required crisis training and ~~under the clinical~~ supervision ~~of a mental health professional on the team~~. The team must have at least two members, with at least one member providing on-site crisis intervention services when needed.

D. If possible, at least two members must confer in person or by telephone about the assessment, crisis treatment plan, and necessary actions taken.

E. If a recipient's crisis is stabilized, but the recipientneeds a referral to other services, the team must provide referrals to these services.

5. Crisis stabilization. Crisis stabilization is an individualized mental health service designed to restore a recipient to the recipient's prior functional level.

~~E. Crisis stabilization cannot be provided without first providing crisis intervention.~~

F. Crisis stabilization is provided by a mental health

13.d. Rehabilitative services. (continued)

professional, a clinical trainee, a mental health practitioner who is under theclinical supervision of a mental health professional, or a mental health rehabilitation worker or certified peer specialist who meets the qualifications on pages 53c - 53d.1, who works under the direction of a mental health professional or a mental health practitioner, and works under the clinical supervision of a mental health professional.

G. Crisis stabilization may be provided in the recipient's home, another community setting, or a supervised, licensed residential program (that is not an IMD) that provides short-term services. Stays in excess of 10 days in a month require authorization from the Department. If provided in a supervised, licensed residential program, the program must have 24-hour-a-day residential staffing, and the staff must have 24-hour-a-day immediate access to a qualified mental health professional, clinical trainee or qualified mental health practitioner.

H. A crisis stabilization treatment plan must be developed, and services must be delivered according to the plan. A plan must be completed within 24 hours of beginning services and developed by a mental health professional, clinical trainee or ~~a~~mental health practitioner~~ under the clinical supervision of a mental health professional~~. At a minimum, the plan must contain:

1) ~~A list of~~ Information on problems, strengths and resources identified in the assessment;
2) ~~A list of the recipient's strengths and resources~~ identification of crisis assistance that has been helpful to the recipient in the past;
3) Concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement;
4) Specific objectives directed toward the achievement of each one of the goals;
5) Documentation of the participants involved in the service planning. The recipient, if possible, must participate;
6) Planned frequency and type of services initiated;
7) The crisis response action plan if a crisis should occur; and
8) Clear progress notes on the outcome of goals.

E. For a crisis service delivered in a residential setting, the activities of crisis assessment and intervention must be included in the provision of crisis stabilization. Otherwise, a crisis stabilization service must not be provided without providing crisis intervention first.

13.d. Rehabilitative services. (continued)

6. **Community intervention** is the consultation with relatives, guardians, friends, employers, treatment providers, and other significant people, in order to change situations and allow the recipient to function more independently. The consultation must be directed exclusively to the treatment of the recipient.

~~Telemedicine services. Crisis response services,~~ ~~except residential crisis stabilization services, that are otherwise covered as direct face-to-face services may be provided via two-way, interactive video if medically appropriate to the condition and needs of the recipient.~~

The services below are not eligible for medical assistance payment as mental health crisis response services:
1. Recipient transportation services.
2. Services provided by a nonenrolled Medicaid provider.
3. Room and board.
4. Services provided to a recipient admitted to an inpatient hospital.
5. Services provided by volunteers.
6. Direct billing of time spent "on call" when not providing services.
7. Provider service time paid as part of case management services.
8. Outreach services, defined on page 53g.

- **Intensive outpatient program dialectical behavior therapy services** are approved by a mental health professional as defined in item 6.d.A, with specialized skill in dialectical behavior therapy, following a comprehensive evaluation which includes a diagnostic assessment, functional assessment and review of prior treatment history. A comprehensive evaluation completed by ~~a mental health practitioner working as~~ a clinical trainee must be reviewed and signed by the mental health professional~~ who is the clinical supervisor~~. Services are provided pursuant to an individual treatment plan.

A recipient appropriate for dialectical behavior therapy must have mental health needs that cannot be met with other available community-based services or that must be provided concurrently with other community based services and:

1. have a diagnosis of borderline personality disorder; or

13.d. Rehabilitative services. (continued)

2. have multiple mental health diagnoses and is exhibiting behaviors characterized by impulsivity, intentional self-harm behavior and is at significant risk of death, significant morbidity, disability and/or severe dysfunction across multiple domains.

A recipient must:

1. Understand and be cognitively capable of participating in dialectical behavior therapy as an intensive therapy program and be able and willing to follow program policies and rules assuring safety of self and others; and

2. Be at significant risk of one or more of the following if dialectical behavior therapy is not provided:
a. a mental health crisis
b. requiring a more restrictive setting (such as hospitalization)
c. decompensation
d. engaging in intentional self-harm behavior

Components of dialectical behavior therapy

1. Individual Dialectical Behavior Therapy
Individual dialectical behavior therapy is a combination of individualized rehabilitative and psychotherapeutic interventions to treat suicidal and other dysfunctional coping behaviors and reinforce the use of adaptive skillful behaviors by:
a. identifying, prioritizing and sequencing behavioral targets;
b. treating behavioral targets;
c. generalizing dialectical behavior therapy skills to recipients' natural environment;
d. measuring progress toward dialectical behavior therapy targets;
e. managing crisis and life-threatening behaviors; and
f. assisting recipients to learn and apply effective behaviors in working with other treatment providers.

13.d. Rehabilitative services. (continued)

Individual dialectical behavior therapy is provided by a mental health professional ~~or a mental health practitioner working as~~ a clinical trainee as defined in item 6.d.A. who is employed by, affiliated with or contracted by a dialectical behavior therapy program certified by the Department.

2. **Group dialectical behavior therapy skills training**

Group dialectical behavior therapy is a combination of individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group format to reduce suicidal and other dysfunctional coping behaviors and restore function through teaching adaptive skills in the following areas:

d. Cognitive restructuring, anger and crisis-management skills necessary to tolerate distress and regulate emotion;

e. Basic living, behavior management, engagement, leisure and social skills necessary to function in the community;

f. Assertiveness, interpersonal and problem solving skills necessary for interpersonal effectiveness.

Group dialectical behavior therapy skills training is provided by two mental health professionals as defined in item 6.d.A. or a combination of a mental health professional co-facilitating with ~~a mental health practitioner working as~~ a clinical trainee as described in item 6.d.A.; or a mental health practitioner as defined at pages 54c and c.1 of item 13d, who are employed by, affiliated with or contracted by a dialectical behavior therapy program certified by the Department.

Provider Qualifications, Standards, Training and Supervision

3. Programs are certified by the Department to provide dialectical behavior therapy program components if they meet the following criteria:

a. hold current accreditations as a dialectical behavior therapy program from a nationally recognized certifications and accreditation body or submit to the commissioner's inspection and provide evidence that the dialectical behavior therapy provider will continuously meet ~~the~~ those requirements of ~~Minnesota Rule 9505.0372, subpart 10.~~; and

b. enroll as a Minnesota Healthcare Program provider;

c. Collect and report client-level and program outcomes as specified by the department ; ~

d. maintain a program manual that outlines the dialectical behavior therapy program's policies, procedures, and practices ~~which meet the criteria of Minnesota rule 95905.0372, subpart 10~~

4. Programs consist of persons who are trained in dialectical behavior therapy treatment and meet the following qualifications, training and supervision standards.

Dialectical behavior therapy team leads must:

1. Be a mental health professional as defined in item 6.d.A. who is employed by, affiliated with or contracted by a dialectical behavior therapy program certified by the Department;
2. Have appropriate competencies and working knowledge of the dialectical behavior therapy principles and practices; and
5. Have knowledge of and ability to apply the principles and practices of dialectical behavior therapy consistently with evidence-based practices.

Dialectical behavior therapy **team members** providing individual dialectical behavior therapy or group skills training must:

1. Be a mental health professional as defined in item 6.d.A. or be a mental health practitioner as defined on pages 54Cc and c.1 of this item or ~~a mental health practitioner working as~~ a clinical trainee, who is employed by, affiliated with or contracted with a dialectical behavior therapy program certified by the Department;

13.d. Rehabilitative services. (continued)

9. Have or obtain knowledge of and ability to apply the principles and practices of dialectical behavior therapy consistently with evidence-based practices within the first six months of becoming part of a dialectical behavior therapy program

10. Participate in dialectical behavior therapy consultation team meetings; and

11. For mental health practitioners and clinical trainees, receive ongoing ~~clinical~~ supervision by a mental health professional who has appropriate competencies and working knowledge of the dialectical behavior therapy principles and practices.

13.d. Rehabilitative services. (continued)

~~7. Provider service time paid as part of case management services.~~
~~8. Outreach services, defined on page 54g.~~

- Assertive community treatment (ACT) services are recommended by a mental health professional defined in item 6.d.A. after a diagnostic assessment and a functional assessment. They are provided pursuant to an individual treatment plan. Recipients must be over age 18. Individuals age 16 or 17 may receive ACT services upon approval by the Department.

  The following are eligible to provide ACT services:

  1. County or other entity certified by the Department.
  2. An entity seeking to serve a subpopulation of recipients if the provider demonstrates to the Department that the subpopulation:

     a. requires a specialized program that is not available; and

     b. is of such a low incidence that it is not feasible to develop a program serving a single county or regional group of counties.

  3. A facility of the Indian Health Service or a facility owned or operated by a tribe or tribal organization and funded by either Title I of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, or Title I of the Indian Self-Determination and Education Assistance Act, P.L. 106-260, operating as a 638 facility.

  Provider Qualifications, Training and Supervision
  ACT services are provided by a multidisciplinary staff using a total team approach and assertive outreach for treatment in a recipient's environment. The team includes a clinical supervisor who is a mental health professional as ~~defined on page 54e~~defined in item 6.d.A, and other staff consistent with the Tool for Measurement of Community Assertive Treatment~~Dartmouth Assertive Community Treatment Scale, which establishes national fidelity standards~~. Team members include:

  1. A **psychiatric care provider**, who is either a licensed psychiatrist or an advanced practice registered nurse who qualifies as a mental health professional under item 6.d.A;

13.d. Rehabilitative services. (continued)

2. A **nurse**, who is either a registered nurse, or an advanced practice registered nurse;
3. A **specialist in co-occurring disorders**, who has received Department approved training on co-occurring disorders, and is either a licensed alcohol and drug counselor; a licensed professional counselor with a master's degree, which included 120 hours of a specified course of study in addiction studies with 440 hours of post-degree supervised experience in the provision of alcohol and drug counseling as defined in this item; a mental health practitioner, as defined in this item; or a mental health professional as defined in item 6.d.A.
4. A **vocational specialist**, who has at least one year experience in providing employment services or advanced education that involved field training in vocational services to individuals with mental illness, or has completed a Department approved training program; and is either a mental health practitioner as defined in this item, or a mental health professional as defined in item 6.d.A.
5. A **mental health certified peer specialist (level I or II)** as defined in this item.

~~The team members must meet the qualifications, training and supervision standards that apply to adult rehabilitative mental health services.~~

The team must provide the following:

1. ~~The components of adult rehabilitative mental health services.~~
2. ~~Integrated dual diagnosis treatment.~~
3. ~~Medication monitoring and training in medication self-administration.~~
4. ~~Illness management and recovery.~~
5. ~~Case management.~~
6. ~~Psychological support and skills training.~~
7. ~~Consultation with relatives, guardians, friends, employers, treatment providers, and other significant people, in order to change situations and allow the recipient to function more independently. The consultation must be directed exclusively to the treatment of the recipient.~~
8. ~~Crisis services, including development of a crisis plan with the recipient.~~

13.d. Rehabilitative services. (continued)

1. assertive engagement;
2. psychosocial rehabilitative services that develop and enhance a client's psychiatric stability, including basic living and social-skills therapies;
3. treatment of co-occurring mental illness and substance use disorder, including assertive outreach, goal setting, relapse prevention, and related services;
4. crisis assessment and intervention;
5. family psychoeducation and support when provided for the direct benefit of the client;
6. skills therapies directed at housing-related activities and supports, including individual housing-transition skills and individual housing and tenancy-sustaining skills;
7. medication education, assistance, and support;
8. mental health certified peer specialists services;
9. health and wellness self-management services;
10. symptom management; and
11. empirically supported, psychotherapeutic interventions to address mental health symptoms and behaviors.

- **Intensive Residential Treatment Services (IRTS)** are recommended by a mental health professional defined in item 6.d.A. ~~after a diagnostic assessment and a functional assessment. They~~ and are provided pursuant toan individual treatment plan. A diagnostic assessment and functional assessment are required to establishing continuing eligibility and for service delivery planning.

  ~~These services are provided to a recipient~~ age 18 and older ~~meeting the same eligibility requirements for ACT services, but the recipient also requires the level of care and supervision provided in a residential setting.~~ These 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 are directed toward a targeted discharge date with specified recipient outcomes and are consistent with evidence-based practices.

13.d. Rehabilitative services. (continued)

An individual is eligible for Intensive Residential Treatment Services:

(1) is age 18 or older;

(2) is eligible for medical assistance;

(3) is diagnosed with a mental illness;

(4) because of a mental illness, has substantial disability and functional impairment in three or more domains within the client's functional assessment, so that self-sufficiency is markedly reduced;

(5) has one or more of the following: a history of recurring or prolonged inpatient hospitalizations in the past year, significant independent living instability, homelessness, or very frequent use of mental health and related services yielding poor outcomes; and

(6) in the written opinion of a licensed mental health professional, has the need for mental health services that cannot be met with other available community-based services, or is likely to experience a mental health crisis or require a more restrictive setting if intensive rehabilitative mental health services are not provided.

The following are eligible to provide intensive residential treatment ~~residential rehabilitative~~ services:

2. A county-operated or non-countyoperated entity certified by the Department.

~~4. An entity seeking to serve a subpopulation of recipients if the provider demonstrates to the Department that the subpopulation:~~
~~a. requires a specialized program that is not available from county-approved entities; and~~
~~b. is of such a low incidence that it is not feasible to develop a program serving a single county or regional group of counties.~~

5. A facility of the Indian Health Service or a facility owned or operated by a tribe or tribal organization and funded by either Title I of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, or Title I of the Indian Self-Determination and Education Assistance Act, P.L. 106-260, operating as a 638 facility.

Each provider must have a 24-hour residential care and program services license to provide services for five to sixteen adults with mental illness.

Provider Qualifications, Training and Supervision

Intensive residential treatment services are providedby a multidisciplinary staff for recipients with serious mental illness. The team includes a ~~clinical~~ supervisor who is a mental health professional as defined on page 54e and sufficient staff to comply with the staffing ratio, which

13.d. Rehabilitative services. (continued)

is at least one staff for every nine recipients for each day and evening shift. If more than nine recipients are present at the residence, there must be a minimum of two staff during day and evening shifts, one of whom must be a mental health professional, clinical trainee or a mental health practitioner.

Team members must meet the qualifications, training and supervision standards that apply to adult rehabilitative mental health services, except that mental health rehabilitative workers acting as overnight staff need only meet the qualifications listed in item 2, subitems A through C on page 53c.1. Members of the team provide only those services that are within their scope of practice. A mental health rehabilitation worker under the supervision of a mental health professional can provide skills training and education, medication monitoring, resident supervision and direction, inter-agency coordination, and crisis services.

The team must provide the following:

10. The components of adult rehabilitative mental healthservices.
11. ~~Integrated dual diagnosis~~Co-occurring substance use disorder treatment.
12. ~~Medication monitoring and training in medication self-administration.~~health services and administration of medication
13. Illness management and recovery.
14. Psychological support and skills training.
15. Consultation with relatives, guardians, friends, employers,treatment providers, and other significant people, in orderto change situations and allow the recipient to function more independently. The consultation must be directed exclusively to the treatment of the recipient.
16. Crisis services.
17. Resident supervision and direction.
18. ~~Inter-agency coordination.~~Referrals for other services in the community.

The services below are not eligible for medical assistance payment as intensive residential treatment services:

1. Recipient transportation services otherwise reimbursed under this Attachment.
2. Services billed by a nonenrolled Medicaid provider.

13.d. Rehabilitative services. (continued)

3. Services provided by volunteers.
4. Direct billing of days spent "on call" when not providing services.
5. Job-specific skills services, such as on-the-job training.
6. Performance of household tasks, chores, or related activities for the recipient.
7. Provider service time eligible for payment as case management services.
8. Outreach activities, as defined for adult rehabilitative mental health services on page 53g.
9. Inpatient hospital services. This includes services provided by an institution for mental disease.

~~**Telemedicine services**. Physicians' services provided to recipients through the intensive residential treatment services benefit, which are otherwise covered as direct face-to-face services, may be provided via two-way, interactive video if medically appropriate to the condition and needs of the recipient.~~

13.d. Rehabilitative services. (continued)

Substance Use Disorder Services are provided according to an individual recipient's treatment plan by:

1) An entity licensed by the Minnesota Department of Human Services to provide substance use disorder services. This provider is qualified to provide all substance use disorder services.

2) An entity licensed by American Indian tribal governments to provide substance use disorder services. This provider is qualified to provide all substance use disorder services.

3) A Recovery Community Organization certified by the Department. This provider is qualified to provide peer recovery services.

4) A county entity certified by the Department. This provider is qualified to provide comprehensive assessments, ~~and~~ treatment coordination, and peer recovery support services.

5) A licensed professional, as described below, in private practice is qualified to provide all substance use disorder services with the exception of peer recovery support services.

Substance Use Disorder services include:

1. **Comprehensive assessment.** A face-to-face assessment performed by a qualified professional according to the American Society of Addiction Medicine's multidimensional assessment criteria. The assessment incorporates information describing the scope of a recipient's substance use, need for treatment services, and personal strengths that support recovery. The assessment is the basis for the recipient's individualized, person-centered treatment plan.
2. **Individual and group therapy**. This service assists the beneficiary with achieving the goals developed in the treatment plan and with the establishment of a personal recovery plan by identifying problems and implementing strategies to address, minimize, or reduce the inappropriate use and effects of chemicals through a combination of skills therapy, counseling, and service coordination. Therapy may also include consultation with relatives, guardians, close friends, and other treatment providers. The consultation is directed exclusively to the treatment of the recipient.

   Where identified in a client treatment plan, individual and group therapy may include relationship counseling to help the client identify the impact of their substance use disorder. Qualified professionals may also facilitate access to additional services identified in a client's treatment plan which could include therapeutic recreation, stress management, physical well-being, living skills development, employment or educational services, and socialization skills development.

   ~~**Medication assisted therapy**. This service uses medication as a therapeutic support in conjunction with individual and group therapy. This includes but is not limited to methadone, naltrexone, and buprenorphine.~~

13.d. Rehabilitative services. (continued)

3. **Medication assisted therapy**. This service uses medication as a therapeutic support in conjunction with individual and group therapy. This includes but is not limited to methadone, naltrexone, and buprenorphine.
4. **Treatment coordination**. Treatment coordinators synchronize health services with identified patient needs, to facilitate the aims of the care plan. Activities include treatment follow-up, on-going needs assessments, life skills advocacy, education, service referral, and documentation.
5. **Peer recovery support services**. Recovery peers provide mentoring, education, advocacy and nonclinical recovery support to the recipient.

Up to four hours of individual or group treatment, two hours of treatment coordination, and two hours of peer support services may be covered prior to the comprehensive assessment and treatment plan, based on a positive result of a Screening, Brief Intervention, and Referral to Treatment (SBIRT).

Provider Qualification and Training
The following personnel can provide substance use disorder services:

1) A licensed alcohol and drug counselor is qualified to provide the comprehensive assessment, individual and group therapy, medication assisted therapy, and treatment coordination.

2) A counselor supervisor of licensed alcohol and drug counselors must have three years of work experience as a licensed drug and alcohol counselor and is qualified to provide the comprehensive assessment, individual and group therapy, medication assisted therapy, and treatment coordination.

3) Licensed Social workers, licensed marriage and family therapists, and licensed professional counselors who have a master's degree, which included 120 hours of a specified course of study in addiction studies with 440 hours of post-degree supervised experience in the provision of alcohol and drug counseling. This provider is qualified to provide the comprehensive assessment, individual and group therapy, medication assisted therapy, and treatment coordination.

4) Personnel providing substance use disorder services at programs licensed by American Indian tribal governments must be credentialed according to the standards set by the individual tribal governing body, and are qualified to provide the comprehensive assessment, individual and group therapy, medication assisted therapy, peer recovery support services, and treatment coordination.

5) A mental health professional who has at least 12 hours of training in substance use disorder and treatment is qualified to provide the comprehensive assessment.

6) A clinical trainee practicing under the supervision of a mental health professional who has at least 12 hours of training in substance use disorder and treatment is qualified to provide the comprehensive assessment.

7) An advanced practice registered nurse who has at least 12 hours of training in substance use disorder and treatment is qualified to provide the comprehensive assessment.

13.d. Rehabilitative services. (continued)

- Peer recovery support services;
- A health assessment;
- Nursing care provided 24 hours per day, including daily medical evaluation;
- Medication administration; and
- A comprehensive assessment.

A **medically monitored program** ~~meets the ASAM level III.7.D level of care criteria by providing~~ provides 24-hour medically supervised evaluation and withdrawal management. This level of care is for individuals whose withdrawal signs and symptoms are sufficiently severe to require ~~medical professionals~~ licensed practitioners but not an inpatient hospital level of care. Services are supervised by a medical director who must be on site seven days a week and available for consultation or onsite recipient monitoring 24 hours per day. A registered nurse must be on site 24 hours a day.

Additionally, a medically monitored program must meet the following staffing requirements:
- The program director, the medical director, or a licensed registered nurse must be present and awake at all times.
- A licensed alcohol and drug counselor is required for every 16 patients served by the program.
- A technician must be awake and on duty at all times for every ten patients served by the program. All staff whose qualifications meet or exceed those for a technician and who are performing the duties of a technician may be counted as a technician for purposes of this requirement. The same individual may not be counted as both a licensed alcohol and drug counselor and a technician.

A medically monitored program must provide the following services as medically appropriate:
- Individual and group therapy;
- Treatment coordination;
- Peer recovery support services;
- A health assessment with the ability for a consultation with a licensed practitioner ~~qualified medical professional~~ if the assessment indicates it is medically necessary;
- Nursing care provided 24 hours per day, including daily medical evaluation;
- Onsite monitoring seven days per week by a qualified medical professional;
- Medication administration and
- A comprehensive assessment.

13.d. Rehabilitative services. (continued)

Provider Qualification and Training

The following personnel can provide substance use disorder services:

1) A licensed alcohol and drug counselor is qualified to provide the comprehensive assessment, individual and group therapy, medication assisted therapy, withdrawal management, and treatment coordination.

2) A counselor supervisor of licensed alcohol and drug counselors must have three years of work experience as a licensed drug and alcohol counselor and is qualified to provide the comprehensive assessment, individual and group therapy, medication assisted therapy, withdrawal management, and treatment coordination.

3) Licensed Social workers, licensed marriage and family therapists, and licensed professional counselors who have a master's degree, which included 120 hours of a specified course of study in addiction studies with 440 hours of post-degree supervised experience in the provision of alcohol and drug counseling. This provider is qualified to provide the comprehensive assessment, individual and group therapy, medication assisted therapy, withdrawal management, and treatment coordination.

4) Personnel providing substance use disorder services at programs licensed by American Indian tribal governments must be credentialed according to the standards set by the individual tribal governing body, and are qualified to provide the comprehensive assessment, individual and group therapy, medication assisted therapy, peer recovery support services, withdrawal management, and treatment coordination.

13.d. Rehabilitative services. (continued)

2) Treatment coordinators that meet the following requirements, and working under the clinical supervision of a licensed professional described above, are qualified to provide treatment coordination services:

- skilled in identifying and assessing a wide range of client needs,
- knowledgeable about local community resources and how to use them,
- have successfully completed ~~30~~ 15 hours of ~~classroom instruction on treatment~~ education or training on substance use disorder, co-occurring conditions, and care coordination for an individual with substance use disorder or co-occurring condition,
- have at least ~~2,000~~ 1,000 hours of supervised experience working with individuals with substance use disorder or co-occurring conditions, or receives treatment supervision at least once per week until obtaining 1,000 hours of supervised experience working with individuals with substance use disorder or co-occurring conditions, and
- have a ~~bachelor's degree in one of the behavioral sciences or a related field or be certified as a Level I alcohol and drug counselor by the upper Midwest Indian Council on Addictive Disorders~~ high school diploma or equivalent or is a mental health practitioner.

3) Recovery peers that meet the following requirements, and working under the clinical supervision of a licensed professional described above, are qualified to provide peer recovery support services:

- a minimum of one year in recovery from substance use disorder;
- credentialed by a certification body approved by the Commissioner;
- successfully complete peer specialist certification training, approved by the Department that teaches specific skills relevant to providing peer support to other consumers; and
- complete 20 hours of relevant continuing education every two years in topics such as ethics and boundaries, advocacy, mentoring and education, and recovery and wellness support.

4) Technicians, working under the clinical supervision of a licensed professional in a withdrawal management program, perform basic medical activities such as checking vitals, performing screenings, and managing basic patient care. A technician must:

- Have a current first aid certification from the American Red Cross, or equivalent organization;
- Have a current CPR certification from the American Red Cross, the American Heart Association, or equivalent organization, and
- The knowledge and ability to perform basic medical screening procedures, first aid, and basic activities of daily living and personal hygiene.

13.d. Rehabilitative services. (continued)

1) A person licensed to practice practical or professional nursing in the state of Minnesota may provide services as part of a withdrawal management program.

2) A medical director is either a physician as described in item 5.a., a clinical nurse specialist as described in in item 6.d.H., or a nurse practitioner as described in item 6.d.E.

3) A qualified medical professional is either a physician as described in item 5.a., a clinical nurse specialist as described in in item 6.d.H., or a nurse practitioner as described in item 6.d.E.

Rehabilitative physical therapy, occupational therapy, and speech, language and hearing therapy services.

Coverage is limited to services within the limitations provided under Items 11.a. to 11.c., Physical therapy services, Occupational therapy services, and Speech, language and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist), except:

13.d. Rehabilitative services. (continued)

1) Services that are provided by a rehabilitation agency that take place in a sheltered workshop in a day training and habilitation center or a residential or group home that is an affiliate of the rehabilitation agency are not covered.
2) Social and vocational adjustment services are not covered, but must be provided as an unreimbursed adjunct to the covered services.

Covered **respiratory therapy services** are those prescribed by a physician and provided by a qualified respiratory therapist.

EPSDT rehabilitative services identified in either an Individualized Family Service Plan or an Individualized Education Plan under the Individuals with Disabilities Education Act (IDEA) and provided to children with IFSPs or IEPs during the school day.

Covered services include: ~~IFSP or IEP~~ evaluations or assessments that are medical in nature and used to determine the need for services as part of an ~~result in IFSPs or IEPs that include covered~~ IEP or IFSP ~~services~~, or determine the need for continued coverage~~ed~~ of services under an IEP or IFSP ~~services~~; speech, language and hearing therapy services; mental health services; physical and occupational therapy; and assistive technology devices.

Covered services also include nursing services, such as catheterization, suctioning, tube feedings, medication management, and ventilator care. Nursing services also includes complex or simple medication administration. Medication administration must be related to a child's disability and included in an IFSP or IEP for treatment of the identified disability.

- Simple medication administration is an exception to the requirement in the following paragraph that EPSDT rehabilitative services identified in an IFSP or IEP must be services otherwise covered in this Attachment.

The services must meet all the requirements otherwise applicable if the service had been provided by a qualified, enrolled provider other than a school district, in the following areas: a covered service, medical necessity, documentation, personnel qualifications, and invoicing and prior authorization requirements.

Appropriate nursing services must be provided pursuant to a physician's order. All other services must be provided pursuant to an order of a licensed practitioner of the healing arts.

13.d. Rehabilitative services. (continued)

Appropriate children's therapeutic services and supports (mental health services) must be provided by a provider certified pursuant to Item 4.b., except that school districts are not required to provide children's therapeutic services and supports that they would not otherwise provide.

Covered services must be furnished by the following personnel:

(1) Audiologists meeting the requirements in 42 CFR Part 440.110.

(2) Occupational therapists certified by the National Board for Certification in Occupational Therapy who maintain state licensure as occupational therapists and meet the requirements of 42 CFR 440.110.

(3) Physical therapists meeting the requirements in 42 CFR Part 440.110.

(4) Speech-language pathologists:

(a) meeting the requirements in 42 CFR Part 440.110;

(b) who hold a masters degree in speech-language pathology; and

(c) who are licensed by the state as speech-language pathologists.

(5) Mental health professionals as defined in item 6.d.A.

(6) Mental health practitioners, practicing under the supervision of mental health professionals,

13.d. Rehabilitative services. (continued)

as defined in item 4.b.

Mental health practitioners cannot provide psychological testing or diagnostic assessments.

(11) Mental health behavioral aides as defined in item 4.b., working under the direction of either mental health professionals who assume full professional responsibility or mental health practitioners under the ~~clinical~~ supervision of mental health professionals who assume full professional responsibility.

(12) Physicians who have a current Minnesota license as a physician.

(13) Registered nurses and licensed practical nurses who have a current Minnesota license as registered nurses or practical nurses.

(14) Clinical trainees as defined in item 6.d.A

13.d. Rehabilitative Services. (continued)

Certified Community Behavioral Health Center Services

Certified Community Behavioral Health Center(CCBHC) services include a comprehensive set of outpatient, community-based behavioral health services and supports that take an integrated, whole-person approach through coordination with physical health and social service providers. All CCBHC services are furnished by qualified individual practitioners affiliated with Minnesota's CCBHCs. The following table of services are provided in accordance with the Rehabilitative Services (§ 13d.) benefit by qualified individual practitioners affiliated with state certified community behavioral health centers. CCBHC services that involve the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service(s) must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

CCBHC Services Included in the Rehabilitative Services Benefit		
Service	**Covered Components**	**Provider Qualifications**
Mental health crisis response services	Crisis response services include crisis assessment, crisis intervention, crisis stabilization and community intervention as listed in the rehabilitative services benefit (item 13.d.)	As listed in the rehabilitative services benefit (item 13.d.)
Mental Health Crisis Response Services for Children	Crisis response services for children include crisis assessment, crisis intervention, and crisis stabilization as listed in the EPSDT benefit (item 4.b.)	As listed under the EPSDT benefit (item 4.b.)
Community Mental Health Center services	Diagnostic assessment, explanation of findings, family, group and individual psychotherapy, including crisis intervention psychotherapy services, multiple family group psychotherapy, psychological testing, medication management, adult day treatment, neuropsychological services, including neuropsychological assessment and neuropsychological testing and 24-hour emergency care as listed in the rehabilitative services benefit (item 13.d.)	Mental health professional defined in item 6.d. A. Mental health practitioner as listed in the rehabilitative services benefit (item 13.d.1.) Clinical Neuropsychologist as listed in the rehabilitative services benefit (item 13.d.)
Adult rehabilitative mental health services (ARMHS)	As listed in the rehabilitative services benefit (item 13.d.)	As listed in the rehabilitative services benefit (item 13.d.1 and 13.d.2.)
Dialectical behavioral therapy	As listed in the rehabilitative services benefit (item 13.d.)	As listed in the rehabilitative services benefit (item 13.d.)
Children's therapeutic services and supports	As listed in the EPSDT services benefit (item 4.b.)	As listed in the EPSDT services benefit (item 4.b.)
Certified family peer specialists	As listed in the EPSDT services benefit (item 4.b.)	As listed in the EPSDT services benefit (item 4.b.)
Substance Use Disorder (SUD) services	Comprehensive assessments, individual and group therapy, SUD treatment coordination, and recovery peer supports (item 13.d.)	As listed in the rehabilitative services benefit (item 13.d.)
Family psychoeducation services	As listed under the EPSDT benefit (item 4.b.). Services provided to the family are in support of the beneficiary.	Family psychoeducation services are provided by a mental health professional, or a mental health practitioner working as a clinical trainee, as defined in Item 6.d.A.
Assertive community treatment	Limited to family psychoeducation services. Assertive community treatment services are under the rehabilitative services benefit (item 13.d.)	As listed in the rehabilitative services benefit (item 13.d.)

13.d. Rehabilitative Services. (continued)

The following table of services currently authorized under the Other Licensed Practitioners Services, (§ 6d.), Physicians' Services (§ 5a.), and Targeted Case Management (Supplement 1) benefits, and provided by qualified individual practitioners affiliated with state certified community behavioral health centers:

CCBHC Services Covered Elsewhere in the State Plan		
Service	**Covered Components**	**Provider Qualifications**
Psychiatric services	Limited to biofeedback training. Psychiatric services are under the physician services benefit (item 5.a)	As listed under the physician services benefit (item 5.a.)
Mental Health Targeted Case Management	As described in Supplement 1 to Attachment 3.1-A/B	As listed in item E.1. of Supplement 1 to Attachment 3.1-A/B
Mental Health Services	Includes the development of individualized treatment plans based on a diagnostic and functional assessment, documents the plan of care and guides treatment interventions, as described in 6.d. A. Other practitioners' services	Provided by a mental health professional as listed in item 6.d.A.

The following table of additional services are provided in accordance with all federal requirements applicable to the 1905(a)(13) benefits, and provided by qualified individual practitioners affiliated with state certified community behavioral health centers:

Other CCBHC Services		
Services	**Covered Components**	**Provider Reuqirements**
Integrated Treatment Plan	The integrated treatment plan is a documented plan of care that, based on the member's goals, guides treatment interventions and documents coordination of medical, psychosocial, emotional, therapeutic, and support needs of their member in a manner consistent with their cultural and linguistic needs. The integrated treatment plan is the result of person and family-centered planning process that includes the member, any family or member-defined natural supports, CCBHC service providers, and care coordination staff.	The integrated treatment plan must be reviewed and signed by a mental health professional as defined in item 6.d.A.
Outpatient withdrawal management	Outpatient withdrawal management is a time-limited service delivered in an office setting, an outpatient behavioral health clinic, or in a person's home by staff providing medically supervised evaluation and detoxification services to achieve safe and comfortable withdrawal from substances and facilitate transition into ongoing treatment and recovery. Services include: assessment, withdrawal management planning, medication prescribing and management, trained observation of withdrawal symptoms and supportive services to encourage the person's recovery.	Outpatient withdrawal management services may be provided by a DEA waivered prescriber to prescribe buprenorphine, a registered nurse under the supervision of a physician, a mental health professional as listed in item 6.d.A., a licensed alcohol and drug counselor listed in item 13.d, or a mental health practitioner under the supervision of a mental health professional as defined in item 6.d.A.

13.d. Rehabilitative Services. (continued)

Other CCBHC Services (cont'd)		
Functional Assessment	The functional assessment is listed in the rehabilitative services benefit (item 13.d.) as a component of adult rehabilitative mental health services (ARMHS) services. A complete functional assessment is an assessment of functional ability identifying and describing functional strengths and deficits, the person's current status within each life area domain, and the linkage between the individual's mental health and the level of functioning. The assessment of functional ability informs the level of care assessment which determines the service intensity needs of the individual.	A mental health professional or practitioner as described in item 6.d.A., a certified peer specialist level II, or mental health rehabilitation worker as described in the rehabilitative services benefit (13.d.)
Certified peer specialist services	Certified peer specialist services are listed in the rehabilitative services benefit (item 13.d.) as a component of adult rehabilitative mental health (ARMHS) services. Certified peer specialists provide non-clinical peer support, promote recipient ownership of the care plan, assist beneficiaries with specific recovery-focused activities, and participate as a member of the mental health team.	Certified Peer Specialist Level I or Level II as listed in the rehabilitative services benefit (item 13.d.3.)

Provider Eligibility

Organizational providers of CCBHC services must be a not for profit or a part of a local government behavioral health authority or operated under the authority of the Indian Health Service, an Indian Tribe, or Tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self Determination Act, or an urban Indian organization pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act.

Providers eligible for reimbursement as a CCBHC must meet certification standards established by the Department in accordance with state law. State certification standards include the following staffing and service delivery requirements:

- **Staffing Criteria:** Staff must have diverse disciplinary backgrounds, have necessary State required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic's population.

- **Availability and Accessibility of Services:** CCBHCs must make services available and accessible to individuals and families of all ages, use a sliding fee scale and may not refuse or limit service based on the person's ability to pay or place of residence.

Additionally, the two activities described below must be performed by all enrolled CCBHCs as a condition of participation. CCBHCs may not bill for these activities, but the cost of performing these activities for Medical Assistance beneficiaries is included in the payment rate described in Attachment 4.19-B.

13.d. Rehabilitative Services. (continued)

- **Care Coordination:** CCBHCs are required to coordinate care across settings and providers for the people served to ensure seamless transitions across the full spectrum of health services. Care coordination includes documenting a plan of care for medical, behavioral health and social services and supports in the integrated treatment plan, assisting with obtaining appointments, confirming appointments are kept, developing a crisis plan, tracking medication, and implementing care coordination agreements with external providers. Care coordination may include psychiatric consultation to primary care practitioners and mental health clinical care consultation.

- **Preliminary Screening and Risk Assessment**

A prospective CCBHC recipient receives a preliminary screening and risk assessment to determine acuity of recipient need. The person is referred to crisis services if immediate need, or scheduled for an evaluation within 1-10 days, based on acuity determined in the assessment.

Designated Collaborating Organizations are entities with a formal agreement with CCBHCs to furnish CCBHC services. Collaborating organizations furnishing services under an agreement with CCBHCs must observe the same service standards and provider requirements as CCBHCs. CCBHCs maintain responsibility for coordinating care and are clinically responsible for services provided by collaborating organizations.

Service Limitations

Services are delivered in accordance with an individual's CCBHC integrated treatment plan.

14. Services for individuals age 65 or older in institutions for mental diseases.

- See items 14.a. to 14.c.

14.a. Services for individuals age 65 or older in institutions for mental diseases - inpatient hospital services.

- Same service limitations apply as those listed in item 1, Inpatient hospital services.

14.b. Services for individuals age 65 or older in institutions for mental diseases - nursing facility services.

- Same service limitations apply to those listed in item 4.a., Nursing facility services.

14.c. Services for individuals age 65 or older in institutions for mental diseases - intermediate care facility services.

- Same service limitations apply as those listed in item 4.a., Nursing facility services.
- Reserved bed services as provided as indicated in Attachment 4.19-C.

15.a. Nursing facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with §1902(a)(31) of the Act, to be in need of such care.

- Same service limitations apply as those listed in item 4.a., Nursing facility services.

15.b. Intermediate care facility services (other than services in an institution for mental diseases) for persons determined, in accordance with §1902(a)(31) of the Act, to be in need of such care including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

- The same service limitations apply as specified in item 15.a.

16. Inpatient psychiatric facilities services for individuals under 22 years of age:

Services are covered for individuals who have reached age 21, but not age 22, only if an individual was receiving such services during the period immediately preceding the individual's 21st birthday. In these cases, services may be continued up to the date an individual no longer requires services or the date the individual reaches age 22, whichever date is earlier.

- For recipients receiving services in a psychiatric hospital or a hospital with an inpatient psychiatric program, ~~T~~the same service limitations apply as specified in item 1, Inpatient hospital services. The facility must be licensed, and surveyed by the state to ensure it meets the requirements to participate in Medicare ~~JCAHO accredited~~.

- Effective January 1, 2017, services may also be provided to recipients residing in a psychiatric residential treatment facility (PRTF). A PRTF is a psychiatric facility licensed, accredited in accordance with 42 C.F.R. §§ 440.160 and 441.151, and enrolled with the Department. The following requirements must be met:
    - The PRTF must satisfy all requirements in 42 C.F.R. Part 483, subpart G, related to restraint and seclusion;
    - The PRTF may only admit recipients whose need for services has been certified as described in 42 C.F.R § 441.153;

- **Provider qualifications**. Services are delivered by a multi-disciplinary team, employed or contracted by the facility that consists of a team leader and other treatment staff. The team is led by either:
    1) A board-eligible or board-certified psychiatrist,
    2) A doctoral-prepared, clinical psychologist and a physician, or
    3) A physician with specialized training and experience in diagnosis and treatment of mental illness, and a psychologist who has a master's degree in clinical psychology.

16. Inpatient psychiatric facilities services for individuals under 22 years of age:

The treatment team must also include at least one of the following:
1) A licensed independent clinical social worker (LICSW),
2) A registered nurse with specialized training, or one year of experience treating people with mental illness;
3) An occupational therapist, as described in item 11.b., with specialized training, or one year of experience treating people with mental illness; or
4) A board-licensed psychologist.

The treatment team must maintain a staffing ratio of at least one staff person to three residents during normal waking hours, and at least one staff person for every ~~four~~ six residents during normal sleeping hours.

- **Covered services.** Covered services include all medically necessary services covered under Medical Assistance and described in the recipient's plan of care. The treatment team must provide the following:

  - Development of the individual plan of care, including review of the plan every 30 days;
  - Daily therapy as described in the plan of care, including:
    - Individual therapy provided at least two times per week;
    - Family therapy provided at least one time per week; and
    - Group therapy as appropriate;
  - Consultation with other professionals including case managers, primary care professionals, community-based mental health providers, school staff, and other members of the child's support structure;
  - Nursing care to patients 24 hours per day, and
  - Discharge planning.

- Services may also be provided under arrangement by licensed professionals who are not part of the treatment team, but have a contractual agreement with the PRTF. Arranged services may be delivered at the facility or in the community, and may be billed by either the facility or the licensed professional.

17. Nurse midwife services.

Payment is limited to services provided within the scope of practice of the certified nurse midwife. In addition to traditional nurse midwife services, services within the scope of practice are:

- annual physical exams;
- prescribing the full range of birth control methods;
- administering Norplant, Depo Provera;
- diagnosing and treating sexually transmitted diseases;
- preconceptual counseling;
- evaluating breast masses and making referrals for follow-up;
- evaluating abdominal pain and making referrals for follow-up;
- evaluating women for hormone replacement therapy; and
- if administering pediatric vaccines as noted in item 5.a., Physicians' services within the scope of their licensure, certified nurse midwives must enroll in the Minnesota Vaccines for Children Program.

18. Hospice care (in accordance with section 1905 (o) of the Act):

A recipient must meet each of the following conditions to receive hospice services under medical assistance:

(1) The recipient must be certified as terminally ill (i.e., the medical prognosis is that the recipient's life expectancy is six months or less, given that the terminal illness runs its normal course) within two calendar days after hospice care is initiated. A recertification statement saying the recipient is terminally ill must be obtained within two calendar days after the recipient's first 90 days of hospice care (within two calendar days after the beginning of the next 90 day period) and before each 60-day period that follows. If the hospice does not obtain written certification within two calendar days after hospice care begins, a verbal certification may be obtained within these two days and a written certification obtained no later than eight days after care begins.

(2) The recipient must live in the recipient's own home, in the community, or in a long-term care facility.

(3) ~~The~~ Recipients over age 21 must sign an election of hospice statement containing the following:
   (a) the name of the hospice;
   (b) an acknowledgment that the recipient understands that the hospice provides palliative, not curative care;
   (c) an acknowledgment that the recipient's right to receive Medicaid payment for certain other Medicaid services (including Medicaid waivers) is being waived; and
   (d) the recipient or legal representative's signature.

(4) Recipients under age 21 must sign an election of hospice statement containing the following:
   (a) the name of the hospice;
   (b) an acknowledgment that the recipient understands that the hospice provides palliative, not curative care; and
   (c) the recipient or legal representative's signature.

(5) The recipient must receive hospice care until the recipient is no longer certified as terminally ill or until the recipient or representative revokes the election of hospice.

18. Hospice care (in accordance with section 1905(o) of the Act: (continued.)

The core services listed below must be provided directly by hospice employees. A hospice may use contracted staff, such as physicians, dentists, optometrists or chiropractors to supplement hospice employees during periods of peak patient loads or other extraordinary circumstances. The hospice remains responsible for the quality of services provided by contracted staff.

(1) Nursing services provided by or under the supervision of a registered nurse.

(2) Medical social services provided by a social worker under the direction of a physician.

(3) Counseling services provided to the terminally ill recipient and the family members or other persons caring for the recipient at the recipient's home. Counseling, including dietary counseling, may be provided to train the recipient's family or other caregiver to provide care and to help the recipient and those caring for the recipient adjust to the recipient's approaching death.

The following additional services must also be made available by the hospice:

(1) Inpatient care including procedures necessary for pain control or acute or chronic symptom management. Inpatient care is provided in a Medicare or medical assistance certified hospital, a nursing facility or an inpatient hospice unit.

(2) Inpatient care for up to five consecutive days at a time to provide respite care for the recipient's family or other persons caring for the recipient at home. Inpatient care is provided in a Medicare or medical assistance certified hospital, a nursing facility, an inpatient hospice unit, or a Medical Assistance certified intermediate care facility.

18. Hospice care (in accordance with section 1905(o) of the Act: (continued.)

(3) Medical equipment and supplies, including drugs. Only drugs or compounded prescriptions approved by the commissioner for inclusion in the Department's Drug Formulary are covered. The drugs must be used primarily to relieve pain and control symptoms for the recipient's terminal illness. Medical appliances and durable medical equipment are included, as well as other self help and personal comfort items related to the palliation or management of the recipient's terminal illness. Medical appliances must be provided by the hospice for use in the recipient's home while the recipient is receiving hospice care. Medical supplies include those specified in the written plan of care.

(4) Home health aide services and homemaker services. Home health aides may provide personal care services. Home health aides and homemakers may perform household services to maintain a safe and sanitary environment in areas of the home used by the recipient. Examples of household services are changing the recipient's bed linens, or light cleaning and laundering essential to the comfort and cleanliness of the recipient. Home health aide services must be provided under the supervision of a registered nurse.

(5) Physical therapy, occupational therapy, and speech/language pathology services provided to maintain activities of daily living and basic functional skills.

(6) Services of a physician, dentist, optometrist, or chiropractor.

(7) Any other items or services specified in the plan of care for which payment may be made.

There are four levels of care into which each day of hospice care is classified.

(1) Routine home care day. This is a day in which the recipient is at home and is not receiving continuous care during a crisis.

18. Hospice care (in accordance with section 1905(o) of the Act: (continued.)

(2) Continuous home care day. This is a day in which the recipient receives predominately nursing services, and may also receive home health aide or homemaker services on a continuous basis during a period of crisis. The hospice must provide at least eight hours of care and bills using the hourly rate for the actual hours of service provided up to 24.

(3) Inpatient care day. This is a day in which the recipient received inpatient care for respite for the caregiver at home. The hospice may bill for up to five consecutive days beginning with the day of admission but excluding the day of discharge. Any respite care days beyond the five consecutive covered days must be billed as routine home care days.

(4) General inpatient day. This is a day in which the recipient receives general inpatient care in a hospital, nursing facility, or inpatient hospice unit for control of pain or management of acute or chronic symptoms that cannot be managed in the home. The hospice may bill for the date of admission, but not the date of discharge unless the recipient is discharged deceased.

Medical assistance will pay a hospice for each day a recipient is under the hospice's care. The limits and cap amounts are the same as used in the Medicare program except that the inpatient day limit on both inpatient respite care days and general inpatient care days does not apply to recipients afflicted with acquired immunodeficiency syndrome (AIDS).

No payment is made for bereavement counseling.

19. · Case management services:

Provided with limitations identified in Supplements 1 through ~~1c~~ 1d to this Attachment.

· Special TB-related services under Section 1902(z)(2)(F) of the Act.

The direct observation of the intake of prescribed drugs by outpatient recipients as described in item 6.d.B.

20. Extended services to pregnant women:

- See items 20.a. ~~through~~ and 20.b.

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends:

- The following are extended services for pregnant women ~~which~~ that vary in amount, duration, and scope from other services under this State Plan.

- For the purposes of item 20.a., ``physician'' includes a doctor of osteopathy pursuant to 42 CFR §440.50(a).

PRENATAL RISK ASSESSMENT: All pregnant women receiving prenatal care services funded by the State of Minnesota will be screened for risk of a poor birth outcome. A copy of the risk assessment will be kept in the recipient's medical record. ~~Factors in the assessment will include:~~

~~(1) lifestyle risk, including use of alcohol and illicit or non-prescription drugs, smoking, diet, and activity;~~
~~(2) medical risk;~~
~~(3) genetic risk;~~
~~(4) pre-term birth risk;~~
~~(5) psycho-social risk, including lack of emotional supports, stress, and lack of parenting skills.~~

~~**Risk assessment** activities include:~~

~~(1) To be eligible for MA reimbursement for the delivery of the enhanced perinatal services, a physician, certified nurse midwife, or nurse practitioner shall complete a risk assessment at the recipient's first prenatal visit (and, optionally, again at approximately 24-28 weeks gestation) on the form supplied by the Department of Human Services.~~

~~(2) Physicians, certified nurse midwives, and nurse practitioners must submit the completed risk assessment form to the Department of Human Services.~~

~~(3) The primary provider (physician, certified nurse midwife, or nurse practitioner) will receive a payment for each risk assessment form submitted to the Department (2 payments per pregnancy; limited to 4 payments per year; i.e. more than one pregnancy in a year).~~

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

~~Eligible Providers: Completion of the risk assessment and submission to Department must be performed by the enrolled primary physician, certified nurse midwife, or nurse practitioner.~~

AT RISK ANTEPARTUM MANAGEMENT: If a woman is found to be at risk of a poor birth outcome based on the prenatal risk assessment, the primary physician or certified nurse midwife is eligible for a one-time ~~MA reimbursement~~ medical assistance payment for additional time management based on the woman's risk status.

CARE COORDINATION: The care coordinator for the at risk pregnant recipient must remain consistent and the relationship between the care coordinator and the recipient must be ongoing, with regular interaction, and based on trust if the process is to be effective. Care coordination services are based upon an individualized plan of care for each at risk pregnant woman after assessing the recipient's needs and risks. The care coordinator must make appropriate referrals to resources that will support a healthy pregnancy and improve birth outcomes, monitor recipient progress, synchronize services, advocate for the recipient to assure access to necessary services and maximize use of the most cost effective and appropriate services.

Care coordination services include:

(1) Definition of a pregnant recipient as "at risk" and requiring special needs based on the initial assessment by the primary physician, nurse midwife, or nurse practitioner ~~utilizing the Department's risk assessment form~~.

(2) Development of an individual plan of care that addresses the recipient's specific needs and risks related to the pregnancy.

(3) Involvement of the recipient, family, and recipient support network in the assessment and plan of care.

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

(4) Provision of enhanced perinatal services by the primary provider him/herself or coordination of referrals to appropriate community resources and health care providers eligible for addressing and meeting the recipient's needs related to the pregnancy.

(5) Advocacy for the recipient in working with the various health care providers.

(6) Directly monitoring on an ongoing basis, or ensuring that monitoring is done to determine whether the recipient is, in fact, receiving enhanced perinatal services in a timely and economical manner and that the service is of expected and adequate quality.

Eligible Providers: Care coordination services must be performed by the primary care physician, physician assistant, certified nurse-midwife, clinical nurse specialist, licensed registered nurse, or nurse practitioner. If performed by a registered nurse, the care plan and critical educational needs identified in the plan must be reviewed and approved by the recipient's primary provider. ~~and a~~ A copy of the care coordination plan must be included in the recipient's medical record.

PRENATAL HEALTH EDUCATION I: Health education for the at risk pregnant woman is a core intervention that is preventive, non-invasive and resource-efficient, and enhances compliance with the recipient's individualized plan of care. Educational services will be based upon the ~~client's~~ recipient's identified risks/needs as determined by the ~~Department of Human Services's~~ prenatal risk assessment ~~form~~, as well as consultation and agreement between the care coordinator and recipient. Designated "at risk" ~~clients~~ recipients require innovative and individualized approaches to prenatal care to effectively meet their educational needs. ~~The Department's~~ Educational interventions will target risk factors, medical conditions and health behaviors that can be alleviated or improved through education. Educational services will begin with the initial assessment visit and continue throughout the perinatal period. Services can be provided on a one-to-one basis, in small group settings, or in classes individualized to the ~~client's~~

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

recipient's own needs and interests. The prenatal health education sessions promote behavior changes in the recipient's daily life that will support a healthy pregnancy and result in an improved perinatal outcome.

Prenatal health education will provide information on:

(1) Description and importance of continued prenatal care
(2) Normal changes due to pregnancy (specific to trimester):
  (a) Maternal anatomy and physiology
  (b) Fetal development
  (c) Emotional/psychosexual issues
(3) Comfort measures
(4) Self-care during pregnancy
(5) Pregnancy danger/warning signs/preterm labor and delivery
  (a) Symptoms of preterm labor
  (b) Self-detection of preterm labor
  (c) Treatment
  (d) Preventive measures
(6) Specific medical conditions
  (a) Diagnosis and significance during pregnancy
  (b) Treatment: medications, activity level, options, and rationale
  (c) Appropriate referrals
(7) Birth process
  (a) Anatomy and physiology of labor and delivery
  (b) Coping skills
  (c) Medical management
  (d) Hospital procedures
  (e) Danger signs
  (f) Communication with health providers

~~**Prenatal Health Education** I must include information to prepare the client for the birth process when the recipient is near the end of the second trimester or early third trimester.~~

~~(1) Anatomy and physiology of labor and delivery~~
~~(2) Coping skills~~
~~(3) Medical management~~
~~(4) Hospital procedures~~
~~(5) Danger signs~~
~~(6) Communication with health providers~~

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

~~A pregnant woman may contribute toward preventing preterm labor and delivery. An at risk woman must be instructed in order to provide optimal preventive care:~~

~~(1) Symptoms of preterm labor~~
~~(2) Self-detection of preterm labor~~
~~(3) Treatment~~
~~(4) Preventive measures~~

Eligible Providers: Prenatal Health Education I services must be performed by ~~a~~ the primary care physician, physician assistant, certified nurse midwife, clinical nurse specialist, licensed registered nurse, nurse practitioner, or a health educator with either a baccalaureate level degree in health education or higher and/or ~~SOPHE (Society for Public Health Education)~~ ICEA (International Childbirth Education Association), Lamaze or NCHEC (National Commission for Health Education Credentialing) certification.

PRENATAL HEALTH EDUCATION II

~~Description:~~ Lifestyle and parenting support educational services supplement the Prenatal Health Education I services, and are necessary for recipients who require more time and specialized education to evoke change in risk behaviors and lifestyles as determined by the ~~Department of Human Services's~~ prenatal risk assessment ~~tool~~. Behavior and lifestyle changes resulting from this early and consistent education may also have long term impacts on improving the health of the mother, baby, and subsequent pregnancies.

Providers will address the individual needs of the at risk pregnant woman ~~which~~ that may include:

(1) Education/assistance to stop smoking, alcohol consumption or use of street drugs
  (a) ~~Decrease smoking alternative~~
  ~~(b)~~ Effects of ~~smoking~~ substance use on mother and fetal development
  (b) Referral to support program ~~to quit~~ if needed

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

~~(2) Education/assistance to stop alcohol consumption~~
~~(a) Emphasize importance of no alcohol during pregnancy~~

~~(b) Effect of alcohol on fetal development~~
~~(c) Referral to support program if needed~~

~~(3) Education/assistance to stop use of street drugs~~
~~(a) Emphasize no safe limit~~
~~(b) Effects of drugs on fetal development~~
~~(c) Referral to support program if needed~~

(2) Education on safe use of OTC/prescription drugs
(a) Consult with primary provider

(3) Environmental/occupational hazards
(a) Identify potential exposure to hazard in ~~client's~~ recipient's own environment
(b) Effects on fetal growth and development
(c) Efforts to minimize exposure
(d) Referrals for follow-up if needed

(4) Stress management
(a) Relaxation techniques
(b) Job/unemployment/school problems
(c) Support services
(d) Communication with health care providers
(e) Coping skills

(5) Communication skills and resources
(a) Family support systems
(b) Health care providers

(6) Building of self-esteem

(7) Prenatal parenting; bonding
(a) Identify and affirm prenatal parenting behaviors

(8) Parenting skills to meet the physical, emotional, and intellectual needs of the infant
(a) Infant needs/cares
(b) Nurturing
(c) Infant feeding preparation
(d) Referral to community resources, if needed

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

(9) Planning for continuous, comprehensive pediatric care following delivery.

Eligible Providers: Prenatal Health Education II ~~services~~ for lifestyle and parenting support must be performed by a the primary care physician, physician assistant, certified nurse midwife, clinical nurse specialist, licensed registered nurse, nurse practitioner, health educator with either a baccalaureate level degree in education or higher and/or ~~SOPHE (Society for Public Health Education)~~ ICEA, Lamaze, NCHEC or IBCLC (International Board Certified Lactation Consultants) certification, or a baccalaureate or master's prepared social worker.

PRENATAL NUTRITION EDUCATION:

~~Description:~~ A nutritional assessment with follow-up reassessment and education for the at risk pregnancy must identify nutritional risks and problems the pregnant woman may already have or be in danger of developing as determined by the prenatal risk assessment ~~form~~. An individualized nutrition care plan will be developed for each pregnant woman based on the assessment of her nutritional status with necessary referrals to food assistance programs as appropriate. The nutrition care plan will be incorporated into the overall individualized plan of care for each woman, and will address the prevention/resolution of identified risks and problems. Nutrition interventions will include individual as well as group nutrition education and follow-up, and will provide information that will assist the pregnant woman in making informed nutritional choices and accepting responsibility to change nutritional behaviors to support a healthy pregnancy and result in an improved perinatal outcome.

The nutritional assessment and education component will include:

(1) An initial assessment of "nutritional risk" based upon height, current and pre-pregnancy weight status, laboratory data, clinical data, and self-reported dietary information ~~utilizing the Department's risk assessment tool~~.

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

(2) Ongoing assessment of the pregnant woman's nutritional status (at least once every trimester) as evidenced by dietary information, adequacy of weight gain in pregnancy, other measures to assess uterine/fetal growth, laboratory data, and clinical data.

(3) Development of an individualized nutrition care plan (to be included in recipient's medical record) that addresses the recipient's own nutritional deficits, prioritization of nutritional needs, proposed interventions and time frame with expected outcomes.

(4) Referral to food assistance programs, if indicated (WIC, food stamps, U.S. Department of Agriculture's Mothers and Children Program).

(5) Nutritional interventions; either individual or group education:
(a) Nutritional requirements of pregnancy are linked to fetal growth and development
(b) Recommended Dietary Allowance for normal pregnancy
(c) Appropriate weight gain
(d) Importance of vitamin/iron supplements and recommendations for taking them
(e) Infant nutritional needs and feeding practices, including breast-feeding

(6) Incorporation of pre/postnatal exercise/physical activity program

Eligible Providers: A ~~nutritional assessment and~~ Prenatal nutrition education must be performed by the primary care physician, physician assistant, certified nurse midwife, clinical nurse specialist, licensed registered nurse with specialized training, nurse practitioner, or a qualified dietitian or nutritionist.

POST PARTUM FOLLOW-UP HOME VISIT:

~~Description:~~ There are many possible sources of stress when the mother takes the new baby home, including: feelings of inadequacy in caring for the child; changes in interpersonal relationships; and new burdens of parental responsibility. This visit gives special

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

emphasis for at risk mothers and infants by following up on pre-identified "risk" behaviors and/or medical conditions. Reinforcement and support must be provided when positive behavior changes related to the pregnancy have been required and incorporated into the recipient's lifestyle. Anticipatory guidance about infant care and development will encourage and promote healthier parenting. It is also imperative for the parent(s) to be able to detect signs and symptoms of distress to the infant that require prompt or emergency treatment. The home visit is necessary to anticipate further needs of the mother or infant that may require additional home visits or referral to appropriate health and social service providers. The post partum follow-up home visit will be in addition to and separate from the six week post partum visit with the recipient's primary provider and will be made within the first two weeks after the mother's discharge from the hospital. Individualized information and consistent reinforcement of previously provided services (based on the care plan) will be offered to the recipient at this time.

The provider will address the following:

(1) Assessment of mother's health
  (a) Follow-up "risk" behaviors, and medical conditions
  (b) Support of positive changes made to date

(2) Physical/emotional changes postpartum
  (a) Anticipatory guidance regarding relationship with partner
  (b) Sexual responses
  (c) Potential stress with family
  (d) Nutritional needs
  (e) Physical activity/exercise

(3) Contraception

(4) Parenting skills/support
  (a) Adapting to parenthood
  (b) Parent/child relationship
  (c) Child care arrangements and support

(5) Grief support if unexpected outcome

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends. (continued)

(6) Parenting sick/preterm infant, if indicated
(a) Follow-up on "risk" factors and conditions

(7) Assessment of infant's health
(a) Infant weight/growth
(b) Infant development and abilities

(8) Infant care
(a) Feeding and infant nutritional needs
(b) Recognition of illness in the newborn
(c) Accident prevention
(d) Immunizations and pediatric care

(9) Identification of community health resources for mother and infant.

(10) Referral to appropriate community health resources for mother and infant.

Eligible Providers: The follow-up home visit must be performed by the recipient's primary care physician, physician assistant, certified nurse midwife, clinical nurse specialist, licensed registered nurse, or nurse practitioner who is able to provide and anticipate needs for guidance. The provider must be able to provide the necessary follow-up and referrals to appropriate medical assistance eligible providers and social service agencies.

Doula Services
Services are limited to childbirth education and support services, which includes emotional and physical support, provided during pregnancy, labor, birth, and postpartum.

Eligible providers: Doula services must be recommended by a licensed practitioner acting within the scope of their practice under state law. They are authorized under the preventive services benefit (42 CFR 440.130(c)). ~~provided under the supervision of a physician, nurse practitioner, or nurse-midwife by a~~ D~~d~~oulas must be certified by one of the following organizations:

- International Childbirth Education Association;
- Doulas of North America (DONA);
- Association of Labor Assistants and Childbirth Educators (ALACE);
- Birthworks;
- Childbirth and Postpartum Professional Association (CAPPA);
- Childbirth International;
- International Center for Traditional Childbearing; or
- Commonsense Childbirth Inc. ;
- Modern Doula Education (MDE); or
- Organization designated by the Commissioner of Health

20.b. Services for any other Medical Condition that May Complicate Pregnancy.

- Services are subject to the same limitations already identified for Inpatient hospital, Physician, and Nurse-midwife, etc.

21. Ambulatory prenatal care.

- Not provided.

22. Respiratory care services in accordance with section 1902(e)(9)(A) through (C) of the Act.

- Not provided.

23. Certified pediatric or family nurse practitioner services.

Coverage is limited to:

(1) Services performed by a pediatric nurse practitioner or family nurse practitioner certified by the American Nurses Credentialing Center or the National Certification Board of Pediatric Nurse Practitioners and Nurses, and provided within the scope of practice of the nurse practitioner's license as a registered nurse; and

(2) The types of services covered by medical assistance as ~~physicians'~~ nurse practitioner services under item ~~5.a.~~ 6.d.E that are within the scope of the nurse practitioner's license as a registered nurse.

24. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary.

- See items 24.a. through 24.e.

24.a. Transportation and other services to assure access to covered services.

~~• Medical transportation must be to or from the site of a covered service to a recipient to be eligible for payment. Medicaid also covers transportation of a full-benefit dual eligible to obtain drugs covered under the Medicare Part D benefit.~~

~~• Transportation of a recipient between providers is a covered service with the following limitations:~~

~~1) Transportation between two long-term care facilities must be medically necessary because the health services required by the recipient's plan of care are not available at the long-term care facility where the client resides. There are two exceptions:~~

~~a) it is an emergency; or~~

~~b) due to the severe winter and spring of 1997, it is necessary to return a recipient to his or her original long-term care facility or to a long-term care facility closer to the original facility. This subitem expires February 1, 1998.~~

~~2) Transportation between two hospitals must be to obtain a medically necessary service that is not available at the hospital where the recipient was when the medical necessity was diagnosed.~~

~~• Payment for transportation of a deceased person is limited to the following circumstances:~~

~~1) If a recipient is pronounced dead after medical transportation is called but before it arrives, service to the point of pick-up is eligible for payment.~~

~~2) If medical transportation is provided to a recipient who is pronounced dead on arrival, the medical transportation is eligible for payment.~~

24.a. Transportation and other services to assure access to covered services. (continued)

~~3) If a recipient is pronounced dead before medical transportation is called, medical transportation is not eligible for payment.~~

~~• To be eligible for the medical assistance payment rate as a life support transportation, the life support transportation must comply with the following:~~

~~1) The provider must be licensed under Minnesota Statutes, §§144.802 and 144.804.~~

~~2) The recipient's transportation must be in response a 911 emergency call, police or fire department, or an emergency call received by the provider.~~

~~3) The medical necessity of the service must be documented by the state report required under Minnesota Statutes, §144.807.~~

~~4) Life support transportation that responds to a medical emergency is eligible for payment for no load transportation only if the life support transportation provided medically necessary treatment to the recipient at the pick-up point of the recipient. The payment is limited to charges for transportation to the point of pick-up and for ancillary services.~~

~~• Special transportation is a covered service if the recipient has a physical or mental impairment that would prohibit the recipient from safely accessing and using a bus, taxi, other commercial transportation, or private automobile.~~

~~Such a recipient must not require life support transportation.~~

24.a. Transportation and other services to assure access to covered services. (continued)

~~Special transportation includes driver-assisted service. Driver-assisted service includes:~~

~~1) passenger pickup at and return to the recipient's residence or place of business;~~

~~2) assistance with admittance of the recipient to the medical facility; and~~

~~3) assistance in recipient securement or in securing of wheelchairs or stretchers in the vehicle.~~

~~Payment eligibility of special transportation is subject to the following limitations:~~

~~1) The special transportation and special transportation to reach a health service outside the recipient's local trade area is provided to a recipient who has been determined eligible for special transportation because of physical or mental impairment.~~

~~2) The cost of special transportation of a recipient who receives day services outside the intermediate care facility for persons with mental retardation is not eligible for reimbursement on a separate claim for payment if transportation expenses are included in the per diem payment to the ICF/MR.~~

~~• Transportation by air ambulance shall be eligible for medical assistance payment if the recipient has a life threatening condition that does not permit the recipient to use another form of transportation.~~

~~• The following costs related to transportation are not eligible for payment as medical transportation:~~

~~1) transportation of a recipient to a hospital or other site of health services for detention that is ordered by a court or law enforcement agency except when life support transportation is a medical necessity;~~

24.a. Transportation and other services to assure access to covered services. (continued)

~~2) transportation of a recipient to a facility for alcohol detoxification that is not a medical necessity;~~

~~3) no load transportation except as allowed for life support transportation;~~

~~4) additional charges for luggage, stair carry of the recipient, and other airport, bus, or railroad transportation services;~~

~~5) airport surcharge;~~

~~6) federal or state excise or sales taxes on air ambulance services;~~

~~7) transportation of a recipient to a non-covered service (e.g., grocery store, health club, place of worship). This does not include transportation of a full benefit dual eligible to obtain drugs covered under the Medicare Part D benefit;~~

~~8) extra attendant charges for a personal care attendant accompanying a recipient; and~~

~~9) separate base rates for the continuation of a special transportation trip beyond the original destination.~~

~~• Local agencies and the transportation coordinator approve payment from administrative funds for meals, lodging, or interpreters for the hearing impaired when such services are necessary to obtain necessary covered MA services.~~

24.a. Transportation and other services to assure access to covered services. (continued)

A. Emergency Transportation Services:

Emergency transportation is transportation for the diagnosis and treatment of a condition, including labor and delivery, that if not immediately diagnosed and treated could cause a person serious physical or mental disability, continuation of severe pain, or death. Emergency transportation usually involves transport to a hospital and does not include those transports that are scheduled in advance.

Covered services include:

1. **Ground Ambulance.** The following ambulance services are covered when provided in the context of an emergency response as described above.

a. Advanced Life Support, Level 1 (ALS1)

Transportation by ground ambulance vehicle, medically necessary supplies and services and an ALS assessment by ALS personnel or the provision of at least one ALS intervention as described below in item b.

b. Advanced Life Support, Level 2 (ALS2)

Transportation by ground ambulance vehicle and medically necessary supplies and services, plus

1. three or more different administrations of medications by intravenous push/bolus or by continuous infusion excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or

2. the provision of at least one of the following ALS procedures: manual defibrillation/cardioversion; endotracheal intubation; central venous line; cardiac pacing; chest decompression; surgical airway; or introsseous line.

24.a. Transportation and other services to assure access to covered services. (continued)

c. Basic Life Support (BLS), Emergency

Transportation by ground ambulance vehicle and medically necessary supplies and services, plus the provision of BLS ambulance services.

d. Specialty Care Transport (SCT)

Specialty care transport means interfacility transportation of a critically injured or ill recipient by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic.

2. Air Ambulance. Emergency transportation by air ambulance shall be eligible for medical assistance payment if the recipient has a life threatening condition that does not permit the recipient to use another form of transportation.

Covered air ambulance services include:
a. Conventional air services, fixed wing.

b. Conventional air services, rotary wing.

B. School-Based Services

- Station-to-station non-emergency medical transportation is a covered service for a child receiving EPSDT rehabilitative or personal care services identified on an Individual Family Service Plan (IFSP) or Individualized Education Program (IEP) under the individuals with Disabilities Education Act (IDEA), who has a physical or mental impairment that would prohibit the child from safely accessing and using common carrier transportation such as a bus, taxi, other commercial transportation, or private automobile to receive the covered IEP service. This service is available only when the child receives another covered IEP service on the same day.

  The IEP/IFSP must document the child's need for a special adaptation to the vehicle such as a wheelchair lift, special harness, safety vest or special car seat or the need for a one-on-one aide on the vehicle.

24.a. Transportation and other services to assure access to covered services. (continued)

C. Coverage Limitations:

- Emergency ambulance medical transportation must be to or from the site of a covered service to a recipient to be covered.

- Emergency ambulance transportation of a recipient between providers is a covered service except that emergency transportation between two hospitals or two long term care facilities must be to obtain a medically necessary service that is not available at the hospital or long term care facility where the recipient was when the medical necessity was diagnosed.

- Coverage for emergency transportation of a deceased person is limited to the following circumstances:

  1) If a recipient is pronounced dead after emergency transportation is called but before it arrives, service to the point of pick-up is covered.

  2) If emergency transportation is provided to a recipient who is pronounced dead on arrival, the medical transportation is covered.

- To be eligible for medical assistance coverage as ambulance transportation, the ambulance transportation must comply with the following:

  1) The provider must be licensed under Minnesota Statutes, 144E.10 and 144E.16.

  2) The recipient's transportation must be in response to a 911 emergency call, police or fire department, or an emergency call received by the provider.

  3) The medical necessity of the service must be documented.

24.a. Transportation and other services to assure access to covered services. (continued)

4) No load emergency ambulance transportation is not covered with the following exceptions:

a. Service to the point of pick-up of a deceased person who is pronounced dead after emergency medical transportation is called but before it arrives.

b. Response to a medical emergency if the ambulance transportation provided medically necessary treatment to the recipient at the pick-up point of the recipient.

c. The coverage is limited to charges for transportation to the point of pick-up and for ancillary services.

24.b. Services of nurses in religious nonmedical health care institutions.

- Not provided.

24.c. Care and services provided in religious nonmedical health care institutions.

- Provided with no limitations.

24.d. Nursing facility services for patients under 21 years of age:

- Same service limitations apply as those listed in item 4.a., Nursing facility services.

24.e. Emergency Hospital Services:

- Emergency services means those medical services required for the immediate diagnosis and treatment of medical conditions that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death or are necessary to alleviate severe pain. ~~Emergency hospital services includes telemedicine consultation services as described in item 5.a., Physicians' services (but only via two-way interactive video).~~

- An outpatient hospital service that is not an emergency but is provided in an area that is designated, equipped, and staffed for emergency services is not eligible for payment as an emergency outpatient hospital service.

- An outpatient hospital service that is not an emergency and which is provided in an area of an outpatient hospital which is advertised, represented, or held out to the public as providing acute, episodic care similar to services provided by a physician-directed clinic is not eligible for payment as an emergency outpatient hospital service.

- Medical records must document that an emergency existed at the time the service was rendered.

25. Home and community care for functionally disabled elderly individuals, as defined, described, and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

- Not provided.

26. Personal care services.

~~Personal care services are provided by personal care provider organizations or by use of the PCA Choice option.~~

~~**A. Personal care provider organizations**~~

~~Personal care services provider qualifications:~~

- ~~Personal care assistants must be employees of or under contract with a personal care provider organization or a fiscal intermediary (PCA Choice)~~

- ~~If a recipient's diagnosis or condition changes, requiring a level of care beyond that which can be provided by a personal care provider, non-Medicare certified personal care providers must refer and document the referral of dual eligibles to Medicare providers (when Medicare is the appropriate payer).~~

- ~~Personal care assistant means a person who:~~

  a) ~~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;~~

  b) ~~is able to effectively communicate with the recipient and the personal care provider organization;~~

  c) ~~is able to and provides covered personal care assistant services according to the~~

26. Personal care services. (continued)

~~specified in the state human services licensing act, or a comparable crime in another jurisdiction, unless the owner or managerial official meets the reconsideration criteria specified in the state human services licensing act;~~

~~b) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and provide proof thereof. The insurer must notify the Department of the cancellation or lapse of policy;~~

~~c) the organization must maintain the required statutory documentation of personal care assistant services in a recipient file, as well as evidence of compliance with personal care assistant training requirements and all notices to recipients regarding personal care assistant service use at a rate likely to exhaust authorized hours prior to the end of the authorization period;~~

~~d) the organization must communicate with the recipient or responsible party about the schedule for use of authorized hours; and~~

~~e) the organization must notify the recipient and county public health nurse in advance, on a Department form, if the monthly number of authorized hours is likely to exhaust the authorized hours prior to the end of the authorization period.~~

~~f) the organization shall comply with all laws and rules governing the provision of personal care assistant services.~~

26. Personal care services. (continued)

~~e) recruits, hires and, if necessary, terminates the personal care assistant;~~

~~f) with assistance from the qualified professional, orients and trains the personal care assistant;~~

~~g) with assistance as needed from the qualified professional or the recipient's physician, supervises and evaluates the personal care assistant;~~

~~h) monitors and verifies in writing the number of hours worked by the qualified professional and the personal care assistant; and~~

~~i) together with the PCA Choice provider, qualified professional, and personal care assistant, enters into a written agreement before services begin.~~

~~The agreement must include:~~

~~1) the duties of the recipient, PCA Choice provider, qualified professional, and personal care assistant;~~

~~2) the salary and benefits for the qualified professional and personal care assistant;~~

~~3) the administrative fee of the PCA Choice provider and services paid for with that fee, including background checks;~~

26. Personal care services. (continued)

~~assistant service use at a rate likely to exhaust authorized hours prior to the end of the authorization period; and~~

~~i) ensures arm's length transactions with the recipient and personal care assistant.~~

~~i) the organization shall comply with all laws and rules governing the provision of personal care assistant services.~~

~~At a minimum, qualified professionals visit the recipient in the recipient's home at least once every year. Qualified professionals report to the appropriate authorities any suspected abuse, neglect, or financial exploitation of the recipient.~~

~~As part of the assessment and reassessment process in item 6.d.B. of this attachment, the following must be met to use, or continue to use, a PCA Choice provider:~~

~~a) the recipient must be able to direct the recipient's own care, or the responsible party for the recipient must be readily available to direct the care of the personal care assistant;~~

~~b) the recipient or responsible party must be knowledgeable of the health care needs of the recipient and be able to effectively communicate those needs;~~

~~c) effective August 1, 2002, the recipient who receives shared personal care assistant services (shared services) must use the same PCA Choice provider; and~~

26. Personal care services. (continued)

~~a) up to 2 times the average number of direct care hours provided in nursing facilities for the recipient's comparable case mix level;~~

~~b) up to 3 times the average number of direct care hours provided in nursing facilities for recipients with complex medical needs, or who are dependent in at least seven activities of daily living and need either physical assistance with eating or have a neurological diagnosis;~~

~~c) up to 60 percent of the average payment rate for care provided in a regional treatment center for recipients who exhibit, or that without supervision, observation, or redirection would exhibit, one or more of the following behaviors:~~

~~1) self-injury;~~

~~2) physical injury to others; or~~

~~3) destruction of property;~~

~~d) up to the amount medical assistance would pay for care provided in a regional treatment center for recipients referred by a regional treatment center preadmission evaluation team; or~~

~~e) up to the amount medical assistance would pay for facility care for recipients referred by a long-term care consultation team; and~~

26. Personal care services. (continued)

~~nurse, may complete a service update on forms developed by the Department. If a service update is completed, it substitutes for the annual reassessment described in item 6.d.B. of this attachment, except that PCA Choice consumers must have a face-to-face assessment at least annually.~~

- ~~Recipients or responsible parties utilizing either PCA Choice or PCA provider organizations have the choice to request qualified professional supervision or to supervise the PCA themselves. A reasonable amount of time for the provision of supervision shall be authorized.~~

- ~~Personal care assistant services are provided for recipients who live in their own home if their own home is not a hospital, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), institution for mental disease, or licensed health care facility.~~

- ~~Recipients may use approved units of service outside the home when normal life activities take them outside the home. Effective July 1, 1996, total hours for personal care assistant services, whether performed inside or outside a recipient's home, cannot exceed that which is otherwise allowed for personal care assistant services in an in-home setting.~~

- ~~Recipients may receive shared personal care assistant services (shared services), defined as providing personal care assistant services by a personal care assistant to two or three recipients at the same time and in the same setting. For purposes of this item, "setting" means the home or foster care home of one of the recipients, a child care program in~~

26. Personal care services. (continued)

~~d) revocation by the recipient or responsible party of the shared service authorization, or the shared service to be provided to others in the recipient's home, or the shared services to be provided outside the recipient's home;~~

~~e) if a qualified professional is requested by any one of the recipients or responsible parties, supervision of the shared personal care assistant services by the qualified professional, including the date, time of day, number of hours spent supervising the provision of shared services, whether the supervision was face-to-face or another method of supervision, changes in the recipient's condition, and shared services scheduling issues and recommendations;~~

~~f) if a qualified professional is requested by any one of the recipients or responsible parties, documentation by the qualified professional of telephone calls or other discussions with the personal care assistant regarding services being provided to the recipient; and~~

~~g) daily documentation of the shared services provided by each identified personal care assistant including:~~

~~1) the names of each recipient receiving shared services together;~~

~~2) the setting for the shared services, including the starting and ending times that the recipient received shared services; and~~

26. Personal care services. (continued)

~~consider and document in the recipient's health service record:~~

~~1) the additional qualifications needed by the personal care assistant to provide care to several recipients in the same setting;~~

~~2) the additional training and supervision needed by the personal care assistant to ensure that the needs of the recipient are appropriately and safely met. If supervision by a qualified professional is requested by any one of the recipients or responsible parties, the provider must provide on-site supervision by a qualified professional within the first 14 days of shared services, and monthly thereafter;~~

~~4) the setting in which the shared services will be provided;~~

~~4) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting; and~~

~~5) a contingency plan that accounts for absence of the recipient in a shared services setting due to illness or other circumstances and staffing contingencies.~~

~~The following personal care assistant services are covered under medical assistance as personal care assistant services:~~

26. Personal care services. (continued)

~~Under the flexible use option:~~

~~a) a recipient or responsible party, the public health nurse, and, if the recipient is receiving case management services, the case manager, determine whether the flexible use option is appropriate.~~

~~b) if appropriate, the persons listed in item a) must ensure that the allocation of hours covers the ongoing needs of the recipient over an entire year divided into two six-month periods of flexible use.~~

~~c) the Department will not authorize additional services to supplement a service authorization that is exhausted before the end date under this option, unless the public health nurse determines a change in condition and a need for increased services is established.~~

~~d) the personal care provider organization and the recipient or responsible party, or the PCA Choice provider, must develop a written month-to-month plan of the projected use of personal care assistant services that is part of the care plan and ensures:~~

~~1) that the health and safety needs of the recipient will be met;~~

~~2) that the total annual authorization will not be used before the end of the authorization period; and~~

26. Personal care services. (continued)

~~• The following services are **not covered** under medical assistance as personal care assistant services:~~

~~a) health services provided and billed by a provider who is not an enrolled personal care provider;~~

~~b) personal care assistant services that are provided by the recipient's spouse, legal guardian, parent of a recipient under age 18, or the recipient's responsible party;~~

~~c) effective July 1, 1996, services provided by a foster care provider of a recipient who cannot direct his or her own care, unless a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met;~~

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

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

~~f) sterile procedures;~~

~~g) giving of injections of fluids into veins, muscles, or skin;~~

~~h) homemaker services that are not an integral part of a personal care assistant service;~~

~~i) home maintenance or chore services;~~

26. Personal care services, continued, continued.

I. **Personal care services**

A. Personal care services include:

1. Assistance in **activities of daily living** including eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning;
2. Assistance in **health-related procedures and tasks** per state law including services that can be delegated or assigned by a licensed health care professional to be performed by a personal care assistant, under the supervision of a qualified professional or the direction of the recipient's physician. A licensed health care professional includes a registered nurse, physician, nurse practitioner, and physician assistant;
3. **Observation and redirection of behaviors**; and
4. Assistance in **instrumental activities of daily living** including meal planning and preparation; assistance with paying bills; shopping for food, clothing and other essential items; performing essential household tasks integral to personal care services; communication by telephone and other media; and traveling to medical appointments and to participate in the community. Traveling includes time to accompany the recipient according to the recipient's care plan.

B. Personal care services are provided as follows:

1. Personal care services are provided for recipients who live in their own home if their own home is not a hospital, nursing facility, intermediate care facility for persons with mental retardation (ICF/MR), institution for mental disease, or licensed health care facility.
2. Recipients may use approved units of personal care service outside the home when normal life activities take them outside the home.
3. Personal care services are provided to a recipient who is able to direct his or her own care or to a recipient for whom there is a **responsible party** if the recipient cannot direct his or her own care.
   a. A **responsible party** is a person who:
      i. is knowledgeable about the health care needs of the recipient and is able to effectively communicate those needs;
      ii. provides the support necessary to assist the recipient to live in the community;
      iii. is at least 18 years old;

26. Personal care services, continued, continued.

iv. actively participates in planning and directing personal care services;

v. is not the personal care assistant for the recipient, an owner or employee of a personal care provider agency or county staff acting as part of county employment;

vi. enters into a written agreement with a personal care assistance provider agency on a form determined by the commissioner to perform the duties of the responsible party.

b. A responsible party is required for all recipients when:

i. the recipient is a minor

ii. the recipient is an incapacitated adult with a court-appointed guardian;

iii. the assessment determines a recipient cannot direct their own care and is in need of a responsible party

II. **Provider Qualifications and training**

A. Personal care services are provided by **personal care provider agencies**

1. A **personal care provider agency** means a medical assistance enrolled provider that provides or assists with providing personal care assistance services and includes:

a. Personal care assistance provider agency;

b. Personal care assistance choice agency.

B. Personal care provider agencies must provide the following submissions for initial and ongoing enrollment:

1. Basic agency contact information;
2. Proof of a surety bond, fidelity bond, workers compensation insurance, and liability insurance;
3. Description of the agency's organization and employees identifying all owners, managing employees, board of directors, and the affiliations of the directors, owners, and staff to other service providers;
4. Documentation of compliance with background studies

26. Personal care services, continued, continued.

4. Written policies including employee policies, service delivery policies and grievance policies;
5. Copies of forms used for daily business;
6. Documentation of trainings staff are required to attend;
7. Documentation of completion of required training;
8. Documentation of the agency's marketing practices;
9. Disclosure of ownership, leasing, or management of all residential properties;
10. Documentation of completion of DHS mandatory training by owners, all managing employees, and qualified professionals.

C. Personal care provider agency general duties

1. Pay the staff based on actual hours of services provided
2. Withhold and pay all applicable federal and state taxes
3. Report all suspected neglect and abuse to the appropriate reporting center intake. ~~common entry point, which is an entity in each county serving as a 24 hour intake system for reports of potential abuse and maltreatment.~~
4. Provide the recipient with a copy of the Home Care Bill of Rights at start of service
5. Request reassessments at least 60 days prior to the end of the recipient's current authorization period.
6. Provide training for the personal care assistant based on the assessed needs of the recipient;
7. Provide training about care of a person who is ventilator- dependent, if appropriate.

D. Personal care provider agency criminal background studies

1. The following are required to have successfully completed criminal background studies:
   a. owners who have a five percent interest or more
   c. all managing employees as defined in 42 CFR §455.101
   c. qualified professionals as defined on page 77y
   d. personal care assistants

26. Personal care services, continued

2. A personal care provider agency is barred from enrollment if:
   a. The organization has not initiated background studies on owners and managing employees; or
   b. The organization has initiated background studies on owners and managing employees, but the commissioner has sent the organization a notice that an owner or managing employee of the organization has been disqualified and the owner or managing employee has not received a set aside of the disqualification.

3. Before a qualified professional who works for a personal care assistance provider agency provides services, the personal care assistance provider agency must initiate a background study on the qualified professional, and the personal care assistance provider agency must have received a notice from the commissioner that the qualified professional is:
   a. Not disqualified; or
   b. Disqualified, but the qualified professional has received a set aside of the disqualification.

4. Before a personal care assistant employed by a personal care assistance provider agency is enrolled with the department and provides services for a recipient, a background study must be initiated, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:
   a. Not disqualified;
   b. Disqualified, but the personal care assistant has received a set aside of the disqualification; or

   In the event that a personal care agency discontinues service provision or is disenrolled, a recipient's enrolled personal care attendant can continue to assist the recipient until such time that another background study can be conducted at another provider agency in order to ensure continuity of services and to protect the health and safety of the recipient.

26. Personal care services, continued

E. **Personal care Assistance Choice** option

1. "Personal Care Assistance Choice" is a consumer-directed personal care service option that allows recipients to recruit, hire, terminate, train and supervise their personal care assistants.
2. The enrollment requirements, general duties and policies governing personal care described on pages 77u~~v~~ ~~and~~ through 77w apply to the Personal Care Assistance Choice Option with the following exceptions:
   a. Annual assessments of recipients must be face-to-face.
   b. Personal Care Assistance Choice provider agencies provide fiscal intermediary services which include administrative and financial responsibilities including collection of time cards, billing for services and payment to staff.
   c. The recipient and the Personal Care Assistance Choice provider agency must enter into a written agreement that includes the following components:
      i. Duties of the recipient, qualified professional personal care assistant, and agency
      ii. Salary and benefits
      iii. Administrative fee of the Personal Care Assistance Choice provider agency and services paid for with that fee
      iv. Grievance procedures to respond to complaints
      v. Procedures for hiring and terminating the personal care assistant
      vi. Documentation requirements
   d. The recipient is responsible for training the personal care assistant on his/her individual needs for assistance and for development of a care plan.
   e. If using the shared service option, the recipients may use only one Personal Care Assistance Choice provider agency.
   f. The Personal Care Assistance Choice provider agency must be the employer of personal care assistants and qualified professionals, subject to state employment law and related regulations;
   g. The Personal Care Assistance Choice provider agency owners and managing employees must not be related as a parent, child, sibling, or spouse to the recipient, responsible party, ~~qualified professional,~~ or the personal care assistant;

26. Personal care services, continued

a. The Personal Care Assistance Choice provider agency must ensure arms-length transactions without undue influence or coercion with the recipient and personal care assistant.

3. Under Personal Care Assistance Choice, qualified professionals must visit the recipient in the recipient's home at least once every 180 days, unless the recipient meets the exception criteria listed below in Section E. ~~These visits may be conducted remotely using telephonic or other electronic means.~~

4. Authorization to use the Personal Care Assistance Choice option will be denied, revoked, or suspended if:

a. the public health nurse or qualified professional, as defined below in F.1., determines that use of this option jeopardizes the recipient's health and safety;

b. the parties do not comply with the written agreement; or

c. the use of the option results in abusive or fraudulent billing.

E. **Qualified Professionals**

1. "Qualified professional" means the following professionals ~~as defined in Minnesota Statute § 256b.0625, subdivision 19c,~~ employed by a personal care provider agency: a registered nurse, mental health professional, licensed social worker, or qualified developmental disability specialist.

2. A qualified professional performs the duties of training, supervision, and evaluation of the personal care assistance staff and evaluation of the effectiveness of personal care services. The qualified professional develops a care plan based on the service plan developed by the assessor.

3. Recipients or responsible parties utilizing either Personal Care Assistance Choice or personal care provider organizations must have qualified professional supervision of personal care assistants. Supervision may be conducted remotely if the recipient's primary health care provider has documented that remote supervision is appropriate due to the recipient's chronic health condition or severely compromised immune system.

4. Qualified professionals must report to the appropriate reporting center intake ~~authorities~~ any suspected abuse, neglect, or financial exploitation of the recipient.

G. **Personal Care Assistants**

1. Must be at least 18 years of age, except that a 16 or 17 year old may be a personal care assistant if they meet all of the requirements for the position, have supervision every 60 days, and are employed by only one personal care provider agency;

26. Personal care services, continued

2. Must be employed by a personal care provider agency;
3. Must enroll with the department after clearing a criminal background study;
4. Must effectively communicate with the recipient and personal care provider agency;
5. Must provide covered services according to the care plan, respond appropriately to recipient needs, and report changes to the physician or the qualified professional;
6. Must not be a consumer of personal care services;
7. Must maintain daily written records;
8. Must report any suspected abuse, neglect or financial exploitation of the recipient to appropriate authorities;
9. Must complete standardized training.

III. **Amount, duration and scope of personal care services**

A. Assessment and Service Plan

1. A personal care service plan must be developed at least once every 365 days following an assessment by a public health nurse, or a long term care consultation, which is an assessment of level of care and care planning for purposes of home and community-based waiver programs.
2. If the recipient's medical need changes, the recipient's personal care provider agency may request a change in service authorization or make a referral to another service.
3. In order to continue to receive personal care services after the first year, a service update may be completed. If a service update is completed, it substitutes for the annual reassessment described in item 6.d.B. of this Attachment, except that Personal Care Assistance Choice consumers must have a face-to-face assessment at least annually.

B. Department authorization

1. The Department authorizes all personal care services and supervision services.
2. Authorization is based on the recipient's needs, diagnosis, and condition; an assessment of the recipient; primary payer coverage determination information as required; the service plan; and cost effectiveness when compared to other care options.
3. The Department authorizes total daily personal care services based on the following:

26. Personal care services, continued

a. The person meets the access criteria of having a dependency in an activity of daily living or having the presence of specific behaviors including physical aggression towards self or others, or destruction of property;

b. A person who meets the access criteria above with fewer than two dependencies in activities of daily living is authorized 30 minutes of personal care.

c. A person who has two or more dependencies in activities of daily living is authorized for personal care as follows:

i. The person has been given a home care rating and assigned a daily base amount of time by identifying the number of dependencies in activities of daily living, the presence of complex health related needs and/or the presence of specific behaviors including physical aggression towards self or others, or destruction of property;

ii. The person is authorized for additional time as follows:

- 30 additional minutes per day for a dependency in each of the critical activities of daily living of eating, transferring, mobility, and toileting;
- 30 additional minutes per day for each complex health-related need;
- 30 additional minute per day for each identified behavior description.

4. For people who meet the definition of ventilator-dependent, the Department authorizes a combination of personal care assistance~~,~~ and private duty nursing as defined in item 8, ~~and services provided by Medicare Certified Home Health Agencies as defined in items 7, 7.a. and 7.b.,~~ up to the ~~limit~~amount the Department would pay for ~~all direct care services provided in home that would be included in the payment for care at a hospital;~~ 24 hours per day of private duty nursing at the highest cost level;

5. The Department authorizes a reasonable amount of time for qualified professional supervision of personal care services;

6. Department authorization is also required if more than two reassessments are needed during a calendar year to determine a recipient's need for personal care assistant services.

26. Personal care services, continued

C. **Shared Service Option**

1. **"Shared Service Option"** means personal care services provided in the same setting at the same time by the same personal care assistant for two or three recipients, including recipients selecting PCA Choice, who have entered into an agreement to share services,
2. The shared service option must be appropriate based on the ages of the recipients, compatibility, and coordination of their assessed care needs. A contingency plan must be developed that accounts for absence of a recipient in a shared services agreement due to illness or other circumstances.
3. The shared service option is elected by the recipient or responsible party. The recipient or responsible party may withdraw participation in shared services at any time.
4. There must be documentation of the shared services in each recipient's health record including the training of the personal care assistant, number of hours/units shared, setting, and supervision of staff and services.
5. Each recipient sharing service must use the same personal care assistance provider agency.

D. Flexible Use of Personal Care Services

1. "Flexible Use" means the scheduled use of authorized hours of personal care services, which vary within a service authorization period of up to six months. The recipient/responsible party determines the schedule and communicates this to the personal care provider agency.
2. All recipients, except those assigned to the Minnesota Restricted Recipient program or who have the flexible use option revoked by the Department for misuse or abuse, may use their personal care services hours/units in a flexible manner to meet their needs within the following limits:
    a. Total authorized hours/units must be divided between two six-month date spans.
    b. No more than 75% of total authorized hours/units may be used in a six-month date span.
    c. Health and safety must be assured.
    d. Units cannot be transferred from one six-month date span to another.
    e. Additional PCA hours/units cannot be added unless there is a change in condition.

26. Personal care services, continued

3. The personal care provider agency qualified professional and the recipient or responsible party must develop a written month-to month plan of the projected use of personal care assistant services that is part of the care plan and ensures the:
   a. Health and safety needs of the recipient are met throughout both six-month authorization periods; and
   b. Total hours will not exceed total hours authorized.
4. The provider agency shall monitor the use of personal care assistance services to ensure health and safety needs of the recipient are met throughout the authorization periods.
5. The Department will provide written notice to the provider and the recipient or responsible party when the recipient is at risk of exceeding the personal care assistance services prior to the end of the six-month date span.
6. The Department may take actions if there is misuse and abuse of flexible use of personal care services including, but not limited to:
   a. Revoking flexible use by limiting the authorization period to one month;
   b. Requiring a recipient to have a responsible party;
   c. Requiring a qualified professional to monitor and report services on a monthly basis.

26. Personal care services, continued

IV. Services not covered under medical assistance as personal care services

A. Health services provided and billed by a provider who is not an enrolled personal care provider;

B. Personal care services that are provided by the ~~recipient's spouse~~ parent, stepparent, or ~~paid~~ legal guardian of a recipient under age 18, ~~parent of a recipient under age 18~~a paid legal guardian of a recipient over age 18, or the recipient's spouse or responsible party;

C. Services that are used solely as a child care or babysitting service;

D. Services provided by the residential or program license holder in a residence licensed for more than four persons;

E. Services that are the responsibility or in the daily rate of a residential or program license holder under the terms of a service agreement and administrative rules;

F. Sterile procedures;

G. Giving of injections of fluids into veins, muscles, or skin;

H. Homemaker services that are not an integral part of a personal care service;

I. Home maintenance or chore services;

J. Personal care services when other, more cost-effective, medically appropriate services are available;

K. Services that are not in the individual's service plan;

L. Home care services to a recipient who is eligible for Medicare covered home care services (including hospice), if elected by the recipient, or any other insurance held by the recipient;

M. Services to other members of the recipient's household;

N. Services not specified as covered under medical assistance as personal care assistant services;

O. Application of restraints;

P. Assessments by personal care provider organizations or by independently enrolled registered nurses;

Q. Services provided in lieu of legally required staffing in a residential or child care setting; and

R. Services not authorized by the commissioner or the commissioner's designee.

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 5 to this Attachment.

- Not provided.

28. Freestanding Birth Center services.

Freestanding birth center means a facility licensed as a birth center under Minnesota law that is not a hospital or licensed as part of a hospital.

The following items and services are included in the freestanding birth center facility services payment:

3) Birthing center facility services
4) Nursery care facility services

Services in freestanding birth centers are provided by certified nurse midwives as described in item 17 and traditional nurse midwives providing traditional midwifery services.

Traditional midwifery services are limited to:

3) services performed by a licensed traditional midwife in a licensed birth center; and

4) the types of services within the scope of practice of traditional midwifery under state statute or rule.

29. **Integrated Care Models (FFS Primary Care Case Management)**

Integrated Health Partnership (IHP). IHP entities provide FFS primary care case management services under authority of § 1905(t) of the Social Security Act, which includes location, coordination and monitoring of health care services. The state ensures that it will comply with the applicable beneficiary protections in § 1905(t)(3)as described below. IHP entities are under contract to share cost and savings gained or lost on the total cost of care for certain services provided on a fee-for-service (FFS) basis. Beginning January 1, 2018, Track 1 and Track 2 IHP entities will receive population-based payments for the provision of evaluation, intervention, and health improvement activities of its attributed patients.

Medical assistance beneficiaries are free to choose from any qualified provider, and IHP entities are not under contract to provide medical assistance covered services for a fixed price. Providers who are participating with IHP entities will provide services and submit claims in accordance with fee-for-service requirements.

~~Legacy IHP entities are those with contracts that began before January 1, 2018, and include both virtual and integrated models.~~ Track 1 and track 2 IHP entities ~~differ from legacy IHPs based on~~ have the following characteristics: ~~1)~~ track 1 & 2 IHPs have contracts that begin January 1, 2018, or after, and ~~2)~~ they have also agreed to be evaluated on utilization and health equity metrics. Additionally, b~~B~~oth track 1 and track 2 IHP entities will receive population-based payments.~~;~~ ~~a~~ A track 2 entity differs from a track 1 entity because of its ability to manage the risk of loss. Track 2 IHP entities will share costs and savings gained or lost on the total cost of care for certain services provided on a fee-for-service basis.

IHP entities must be under contract with the state and have demonstrated through the procurement process that:

- The delivery system includes or coordinates the full scope of primary care services;
- Methods and approaches are in place to coordinate care across the spectrum of services included in the payment model;
- Partnerships are in place between the IHP entity and community-based organizations and public health resources will be in place;
- A process is in place to engage patients and their families meaningfully in the care they receive;
- The delivery system has the capacity to receive data from the state via secure electronic processes;

29. **Integrated Care Models (FFS Primary Care Case Management)**

- The delivery system uses data provided by the state to identify opportunities for beneficiary engagement and to stratify their population to determine the care model strategies needed to improve outcomes;

- The delivery system coordinates care with other medical providers who are responsible for pertinent aspects of care; and

- The delivery system participates in quality measurement activities as required by the state and engages in quality improvement activities.

The following beneficiary protections in § 1905(t) apply to this project in the following manner:

- § 1905(t)(3)(A), which requires primary care case managers to maintain reasonable hours of operation and 24-hour availability of referral and treatment, is met because beneficiaries are afforded free choice of providers participating in Medical Assistance;

- § 1905(t)(3)(B), which restricts enrollment to nearby providers, does not apply to this project because there is no enrollment in the project;

- § 1905(t)(3)(C), which requires primary care case managers to ensure the availability of a sufficient number of health care professionals to provide high quality care in a prompt manner, is met in that beneficiaries are afforded free choice of providers participating in Medical Assistance; and in that the attribution methodology ensures that only patients who have a relationship with the participating providers are attributed to the IHP entity;

- § 1905(t)(3)(D), which prohibits discrimination on the basis of health status in enrollment and disenrollment, is met because qualified IHP entities will be prohibited by contract from activities designed to result in selective recruitment and attribution of individuals with more favorable health status.

29. **Integrated Care Models (FFS Primary Care Case Management)**

- § 1905(t)(3)(E), which provides for beneficiary's right to terminate enrollment, does not apply to this project;

- § 1905(t)(3)(F), which requires compliance with § 1932, is applicable to this project as follows:

    - §1903(d)(1), which provides for protections against fraud and abuse, is met in that all providers participating in IHP are enrolled in the Medical Assistance program and bound by the rules of the program;

    - §1932(d)(2), which includes restrictions on marketing by managed care entities, requires the state to monitor marketing efforts on the part of IHP entities; and

    - §1932(e)(4) requires the states to retain the ability to terminate the contract with the IHP entities for failure to meet the terms of the contract.

Qualified IHP ~~demonstration~~ program provider organizations are those that have submitted successful responses to the Department's request for proposal~~s~~ and are under contract with the state to participate in this ~~demonstration~~program, ending three or more years following the ~~implementation~~ execution date of the contract.

~~The state will notify Medical Assistance beneficiaries of the program, including a description of how personal information will be used, and payment incentives, through an annual mailing by May 1 of each performance year, to those beneficiaries who are attributed to the IHP entity at that point in time.~~

The state will ensure Medical Assistance beneficiaries are notified of the information outlined in paragraphs (e) and (f) of 42 CFR §438.10 via written or electronic means.

26. Personal care services, continued

a. The Personal Care Assistance Choice provider agency mustensure arms-length transactions without undue influenceor coercion with the recipient and personal care assistant.

3. Under Personal Care Assistance Choice, qualified professionalsmust visit the recipient in the recipient's home at least onceevery 180 days. ~~These visits may be conducted remotely using telephonic or other electronic means.~~ Qualified professionalsreport to the appropriate authorities any suspected abuse, neglect, or financial exploitation of the recipient.

4. Authorization to use the Personal Care Assistance Choice option will be denied, revoked, or suspended if:

a. the public health nurse or qualified professional, as defined below in F.1., determines that use of this optionjeopardizes the recipient's health and safety;

b. the parties do not comply with the written agreement; or

c. the use of the option results in abusive or fraudulentbilling.

E. **Qualified Professionals**

1. "Qualified professional" means the following professionals asdefined in Minnesota Statute § 256b.0625, subdivision 19c, employed by a personal care provider agency: a registered nurse, mental health professional, licensed social worker, or qualified developmental disability specialist.

2. A qualified professional performs the duties of training, supervision, and evaluation of the personal care assistance staff and evaluation of the effectiveness of personal care services. The qualified professional develops a care plan based on the service plan developed by the assessor.

3. Recipients or responsible parties utilizing either Personal Care Assistance Choice or personal care provider organizations must have qualified professional supervision of personal care assistants.

G. **Personal Care Assistants**

1. Must be at least 18 years of age, except that a 16 or 17 year old may be a personal care assistant if they meet all of therequirements for the position, have supervision every 60 days,and are employed by only one personal care provider agency;

State/Territory: Minnesota

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S)

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: _X_____

II. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

_X_ Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

_X_ A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

_X_ A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unlessit displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 SecurityBoulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

SUPPLEMENTARY NOTES

The following services are not covered under the Medical Assistance program:

1. a health service paid for directly by any other source, including third-party payers and recipients, unless the recipient's eligibility is retroactive and the provider bills the Medical Assistance program for the purpose of repaying the recipient;

2. drugs that are not in the Drug Formulary or, which have not received prior authorization;

3. a health service for which the required prior authorization was not obtained;

4. autopsies;

5. missed or canceled appointments;

6. telephone calls or other communications that were not face-to-face between the provider and the recipient. This does not apply to ~~skilled nurse visits via telehome care and~~ telemedicine services, or oral language interpreter services to persons with limited English proficiency;

7. reports required solely for insurance or legal purposes unless requested by the local agency or the Department;

8. an aversive procedure, including cash penalties from recipients, unless provided according to state rules;

9. a health service that does not comply with Minnesota Rules, parts 9505.0170 to 9505.0475

10. separate charges for the preparation of bills;

11. separate charges for mileage for purposes other than medical transportation of a recipient;

12. a health service that is not provided directly to the recipient, unless the service is a covered service;

SUPPLEMENTARY NOTES (continued)

13. concurrent care by more than one provider of the same type of provider or health service specialty, for the same diagnosis, without an appropriate medical referral detailing the medical necessity of the concurrent care, if the provider has reason to know concurrent care s being provided. In this event, the Department shall pay the first submitted claim;

14. a health service, other than an emergency health service, provided to a recipient without the knowledge and consent of the recipient or the recipient's legal guardian, or a health service provided without a physician's order when the order is required by state rules, or a health service that is not in the recipient's plan of care;

15. a health service that is not documented in the recipient's health care record or medical record as required by state rules;

16. a health service other than an emergency health service provided to a recipient in a long-term care facility that is not in the recipient's plan of care or has not been ordered, in writing, by a physician when an order is required;

17. an abortion that does not comply with 42 CFR §§441.200 through 441.208 or Minnesota Statutes, §256B.0625, subdivision 16;

18. a health service that is of a lower standard of quality than the prevailing community standard of the provider's professional peers. In this event, the provider of service of a lower standard of quality is responsible for bearing the cost of the service;

19. a health service that is only for a vocational purpose or an educational purpose that is not related to a health service;

20. except for an emergency, more than one consultation by a provider per recipient per day; for purposes of this item, "consultation" means a meeting of two or more physicians to evaluate the nature and progress of disease in a recipient and to establish the diagnosis, prognosis, and therapy;

SUPPLEMENTARY NOTES (continued)

21. except for an emergency, or as specified in the recipient's plan of care, more than one office, hospital, long-term care facility, or home visit by the same provider per recipient per day;

22. more than one home health aide visit per recipient per day, and more than two skilled nurse visits per recipient per day, except as specified in the recipient's plan of care;

23. record keeping, charting, or documenting a health service related to providing a covered service;

24. services for detoxification that are not medically necessary to treat an emergency;

25. artificial insemination;

26. reversal of voluntary sterilization;

27. surgery primarily for cosmetic purposes; and

29. ear piercing; ~~and~~

29. ~~sex reassignment surgery~~

30. Effective July 1, 2007, circumcision, unless the procedure is medically necessary.

31. Effective October 1, 2005, payment for visits to a hospital emergency room, that are coded as such visits, which are not for emergency and emergency post-stabilization care or urgent care.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: MINNESOTA

MENTAL HEALTH TARGETED CASE MANAGEMENT SERVICES

A. Target Group (section 1915(g) of the Act):

Case management services are available for individuals who have been determined to have serious and persistent mental illness or severe emotional disturbance.

Serious and persistent mental illness is defined as the condition of a person who has a mental illness and meets at least one of the criteria in items 1 to 5:

1. The person has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months; or

2. The person has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months; or

3. The person has a diagnosis of schizophrenia, bipolar disorder, major depression, schizoaffective disorder, or borderline personality disorder, indicates a significant impairment in functioning, and has a written opinion from a mental health professional (defined in item 6.d.A. of this attachment), in the last three years, stating that the person is reasonably likely to have future episodes requiring inpatient or residential treatment of a frequency described in items 1 and 2, unless ongoing case management or community support services are provided; or

4. In the last three years, the person has been committed by a court as a mentally ill person under Minnesota Statutes, chapter 253B or the person's commitment has been stayed or continued for reasons related to the person's mental illness; or

5. The person: (a) was eligible under items 1 to 4, but the specified time period has expired or the person was eligible as a child with severe emotional disturbance under Minnesota Statutes, §245.4871, subdivision 6; and (b)has a written opinion from a mental health professional, in the last three years, stating that the person is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in item 1 or 2, unless ongoing case management or community support services are provided.

A. Target group (section 1915(g) of the Act): (continued)

6. The person was eligible as a child with severe emotional disturbance and is age 21 or younger.

Severe emotional disturbance is defined as a child under age 18 who has an emotional disturbance and who meets one of the following criteria:

1. The child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance; or

2. The child is a Minnesota resident and is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact; or

3. The child has one of the following as determined by a mental health professional (defined in item 6.d.A. of this attachment):
   i. psychosis or a clinical depression; or
   ii. a risk of harming self or others as a result of an emotional disturbance; or
   iii. psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year; or

4. The child, as a result of an emotional disturbance, has significantly impaired home, school, or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.

B. Areas of the State in which services will be provided:

_x_ Entire state.

Only in the following geographic areas (authority §1915(g)(1) of the Act is invoked to provide services less than statewide): N/A

C. Comparability of Services:

___ Services are provided in accordance with §1902(a)(10)(B) of the Act.

_X_ Services are not comparable in amount, duration, and scope. Authority of §1915(g)(1) of the Act is invoked to provide services without regard to the requirements of §1902(a)(10)(B) of the Act.

D. Definition of Services:

Case management services are activities that are coordinated on an individual client basis and are designed to help persons with serious and persistent mental illness or severe emotional disturbance in gaining access to needed medical, social, educational, financial, or other services necessary to meet the client's needs.

Case Management services include:

1. Completion and regular review of a written functional assessment.

2. The development and regular review of a written individual community support plan for the client based on both a functional and a diagnostic assessment of the client and incorporating the client's individual treatment plans.

3. Assisting the client to access appropriate mental health or other service providers, consistent with §1902(a)(23) of the Act.

4. Coordination of the provision of services consistent with §1902(a)(23) of the Act.

5. Monitoring the client's progress and the effectiveness of the individual community support plan.

6. Monitoring the discharge planning process for a client being discharged from a residential treatment facility, regional treatment center, or inpatient hospital.

D. Definition of Services: (continued)

The monthly payment is limited to the following components of case management services:

1. At a minimum, in order to receive payment:

A. for an adult, the case manage~~ment~~r ~~- service provider~~, must document at least a~~-~~ contact with the adult or the adult's ~~client or the client's~~ legal guardian~~representative~~, which may occur via telephone, interactive video, or in person

B. For a child, the case management service provider must document at least face-to-face contact or contact via interactive video with the child, the child's parent or legal representative.

2. Contacts between the case manager or case manager associate and their clinical supervisor concerning the client.

3. Development, review, and revision of the client's Individual community support plan and functional assessment.

4. Time spent by the case manager or case manager associate traveling to meet face-to-face with a client who resides outside of the county of financial responsibility, or to meet face-to-face with the client's family, legal representative, or primary caregiver.

5. Time spent by the case manager or case manager associate traveling within the county of financial responsibility to meetface- to-face with the client or the client's family, legal representative, or primary caregiver.

D. **Definition of Services** (continued)

The above components of case management services must fall within the following parameters to be eligible for medical assistance ~~payment~~ coverage:

1. For clients in hospitals, NFs, or ICFs/~~MR~~ID, ~~payment~~ coverage for case management services is limited to the last 180 consecutive days before discharge in an effort to establish continuity of care and community-based services recommended by the discharge planning team. This 180-day coverage may not exceed more than six months in a calendar year.

Case management services will not duplicate those provided as part of the institution's discharge plan.

Case management services are not provided to individuals who are inmates of public institutions, or to individuals between the ages of 22 and 64 who are residing in an IMD.

2. A client's continued eligibility for case management services must be determined every 36 months by the local agency. The determination of whether the client continues to have a diagnosis of serious and persistent mental illness or severe emotional disturbance must be based on updating the client's diagnostic assessment or on the results of conducting a complete diagnostic assessment because the client's mental health status or behavior has changed markedly.

The following services are not eligible for ~~payment~~ coverage as case management services:

1. Diagnostic assessment.

2. Administration and management of a client's medications.

3. Legal services, including legal advocacy, for the client.

4. Information and referral services that are part of a county's community social service plan.

5. Outreach services including outreach services provided through the community support services program.

6. Services that are not adequately documented, as required under Minnesota Statutes ~~Rules, part 9520.0920, subpart 1~~.

D. Definition of Services: (continued)

7. Services that are otherwise eligible for payment on a separate schedule under Minnesota Rules, parts 9505.0170 to 9505.0475 or other rules of the Department.

8. Therapy or treatment services.

E. Qualifications of Providers:

A **case management service provider** must be:

1. A local agency, defined as a county or multi-county agency that is authorized under state law as the agency responsible for determining eligibility for the Medical Assistance Program. As the local mental health authority, the local agency is responsible for assuring that persons have access to mental health and other services, consistent with §1902(a)(23) of the Act;

2. An entity under contract with the local agency to provide case management services;

3. An entity meeting program standards set out in rules governing family community support services for children with severe emotional disturbance (when these standards meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 [governing case management for children with severe emotional disturbance] and 9505.0322, excluding subparts 6 [mental health case management services] and 10 [limitations on payment]);

4. A facility of the Indian Health Service or a facility owned or operated by a tribe or tribal organization and funded by Title I of the Indian Self-Determination and Education Assistance Act, P.L. 93-638 or Title V of the Indian Self-Determination and Education Assistance Act, P.L. 106-260 (formerly Title III of P.L. 93-638), operating as a 638 facility; or

5. An entity under contract with a facility of the Indian Health Service or a 638 facility.

E. Qualifications of Providers: (continued)

1. Case managers. The following are considered case managers.

A. Mental health professionals as defined in item 6.d.A and mental health practitioners as defined in item 13.d. of this attachment. Case management supervisors must also meet the criteria for mental health professionals.

B. Individuals who:

(1) are skilled in the process of identifying and assessing a wide range of client needs;

(2) are knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) (a) hold a bachelor's degree in one of the behavioral sciences or related fields including, but not limited to, social work, psychology, or nursing from an accredited college or university, or

(b) (1) have at least three or four years of experience as case manager associates;

(2) are registered nurses with a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; or

(3) qualified before July 1, 1999, as case managers under provisions covering Department recognition of individuals without bachelor's degrees who had 40 hours of approved training in case management skills and at least 6,000 hours of supervised experience in the delivery of mental health services; and,

(4) if providing case management services to children, have experience and training in working with children.

E. Qualifications of Providers: (continued)

- Case managers with at least 2,000 hours of supervised experience in the delivery of services to adults or children must receive regular ongoing supervision and clinical supervision totaling 38 hours per year, of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The remainder may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours. Clinical supervision must be documented in the recipient's record.

- Case managers without 2,000 hours of supervised experience in the delivery of mental health services to adults with mental illness or to children with severe emotional disturbance must begin 40 hours of training approved by the Department of Human Services in case management skills and in the characteristics and needs of adults with serious and persistent mental illness or children with severe emotional disturbance. Case managers must also receive clinical supervision regarding individual service delivery from a mental health professional at least one hour per week until the requirement of 2,000 hours of experience is met.

- A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in mental illness, severe emotional disturbance and mental health services ~~annually~~ every two years.

2. **Case manager associates.** A case manager associate must:

   A. work under the direction of a case manager or case management supervisor;

   B. be at least 21 years of age;

   C. have a high school diploma or equivalent; and

   D. meet one of the following:

      (1) have an associate of arts degree in one of the behavioral sciences or human services;

E. Qualifications of Providers: (continued)

(2) be a registered nurse without a bachelor's degree;

(3) within the previous ten years:

(a) if providing case management services to adults, have three years of life experience With serious and persistent mental illness or as a child had severe emotional disturbance; or

(b) if providing case management services to adults or children, have three years of life experience as a primary caregiver to an adult with serious and persistent mental illness or to a child with severe emotional disturbance;

(4) have 6,000 hours work experience as a nondegreed state hospital technician; or

(5) meet the criterion in state law for mental health practitioner: have at least 6,000 hours of supervised experience in the delivery of services to persons with mental illness.

- Individuals meeting one of the criteria in (1) to (4) above may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in (5) may qualify as a case manager after three years of supervised experience as a case manager associate.

- Case manager associates must meet the following supervision, mentoring, and continuing education requirements:

(a) have 40 hours of preservice training as described on page 8 of this item for case management for clients with serious and persistent mental illness or for children with severe emotional disturbance;

E. Qualifications of Providers: (continued)

(b) receive at least 40 hours of continuing education in mental illness or severe emotional disturbance, and mental health services annually; and

(c) receive at least five hours of mentoring per week from a case management mentor. For purposes of this item, "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision to one or more case manager associates. Mentoring may occur while providing direct services to clients in the office or in the field and may be provided to a case manager associate or to a group of case manager associates. At least two mentoring hours per week must be individual and face-to-face.

3. **Others.**

An immigrant who is neither a case manager nor a case manager associate may provide case management services to adult immigrants with serious and persistent mental illness or to children with severe emotional disturbance who are members of the same ethnic group if the immigrant:

A. is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university;

B. completes 40 hours of training; and

C. for case management services to clients with serious and persistent mental illness, receives clinical supervision at least once a week until he or she becomes a case manager or case manager associate; or

D. for case management services to children with severe emotional disturbance, receives clinical supervision at least once a week until he or she receives a bachelor's degree and 2,000 hours of supervised experience.

F. Freedom of Choice:

The State assures that the provision of case management services will not restrict an individual's free choice of provider in violation of §1902(a)(23) of the Act, except as provided for under §1915(g)(1) of the Act.

1. Eligible recipients' choice of providers of case management services will be limited under §1915(g)(1) to providers defined and described in item E, above.

2. Eligible recipients will have free choice of the providers of other medical care under the State plan.

G. Payment:

Payment for case management services under the State plan is made on a monthly basis and does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

1. Services that are otherwise eligible for payment on a separate schedule under Minnesota Rules, parts 9505.0170 to 9505.0475, or other rules of the Department, are not eligible for payment as case management services.

2. Persons who are receiving home and community-based services under a waiver granted pursuant to §1915(c) of the Act are not eligible to receive the case management services described in this supplement if the services duplicate each other.

3. Persons who are receiving case management services through the Veterans Administration are not eligible for medical assistance covered case management services while they are receiving case management through the Veterans Administration. This payment limitation is applicable only if Veterans Administration reimbursed case management services are substantially similar to case management services covered by medical assistance.

4. Persons who are receiving relocation service coordination services under Supplement 1b to this Attachment are not eligible to receive the case management services described in this supplement for that month.

G. Payment: (continued)

5. Persons who are receiving case management services under Supplement 1c to this Attachment are not eligible to receive the case management services described in this supplement for that month.

6. Persons who are receiving assertive community treatment (ACT) services under item 13.d. to this Attachment are not eligible to receive the case management services described in this supplement for that month, except for the first and last months of ACT services.

7. The Department may suspend, reduce, or terminate the payment to a case management service provider that does not meet requirements, such as reporting. The county of responsibility, or, if applicable, the tribal agency, is responsible for any federal disallowances, but may share this responsibility with its contracted vendors.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: MINNESOTA

CHILD WELFARE - TARGETED CASE MANAGEMENT SERVICES

A. Target Group (section 1915(g) of the Act):

Child welfare-targeted case management services are available for recipients under age 21 who have been assessed in accordance with Minnesota Statutes, section 256F.10 and who meet one or more of the following conditions:

1. at risk of out-of-home placement or in out-of-home placement as defined in Minnesota Statutes, section 257.071, subdivision 1;

2. at risk of maltreatment or experiencing maltreatment, as defined in Minnesota Statutes, section 626.556, subdivision 10e; or

3. in need of protection or services as defined in Minnesota Statutes, section 260.015, subdivision 2a.

B. Areas of State in Which Services will be Provided:

X Entire state.

___ Only in the following geographic areas (authority section 1915(g)(1) of the Act is invoked to provide services less than statewide):

C. Comparability of Services:

___ Services are provided in accordance with section 1902(a)(10) of the Act.

X Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

1. Child welfare-targeted case management services are those activities that assist eligible recipients in gaining access to needed medical, social, educational, and other services as identified in an individual service plan.

Child welfare-targeted case management services include the following activities:

a. assessment of the recipient's need for services to gain access to medical, social, educational, and other related services;

b. the development, completion, and regular review of a written individual service plan based on the assessment of need for case management services to ensure access to medical, social, educational, and other related services;

c. routine contact or other communication with the recipient, the recipient's family, primary caregiver, legal representative, substitute care provider, service providers, or other relevant persons identified as necessary to the development or implementation of the goals of the individual service plan in regard to the status of the recipient, the individual service plan, or goals for the recipient, exclusive of actual transportation of the recipient;

d. coordinating referrals for, and the provision of, child welfare-targeted case management services for the recipient with appropriate service providers, consistent with section 1902(a)(23) of the Act;

e. coordinating with the MA facility discharge planner in the 30-day period prior to the recipient's discharge into the community (this is the only child welfare-targeted case management service provided to patients or residents in a MA-funded facility and is limited to two months per calendar year);

f. coordinating and monitoring the overall service delivery to ensure quality of services;

D. Definition of Services: (continued)

g. monitoring and evaluating services on a regular basis to ensure appropriateness and continued need;

h. completing and maintaining necessary documentation that supports and verifies the above activities;

i. travel to conduct a visit with the recipient or other relevant person necessary to the development or implementation of the goals of the individual service plan; and

j. advocacy on behalf of the recipient through the provision of negotiating and coordinating activities for services that are otherwise inaccessible or unavailable to the client.

2. The following activities are not eligible for payment as child welfare-case targeted management services:

a. assessments prior to opening a case;

b. therapy and treatment services;

c. legal services, including legal advocacy, for the recipient;

d. information and referral services that are part of a county's or tribal social services' community social services plan and that are not related to an eligible recipient;

e. outreach services including outreach services provided through the community support services program;

f. services that are not documented as required under Minnesota Rules, parts 9505.2165 and 9505.2175 ~~to 9505.2195; 9505.0175 to 9505.0475; and 9505.5000 to 9505.5105~~;

g. services that are otherwise eligible for payment on a separate schedule under rules of the Department;

h. case management services that duplicate the same service from another case manager for the same recipient;

D. Definition of Services: (continued)

i. case management services provided to patients or residents in a MA reimbursed facility except as described under D.1.e.; and

j. case management services for children in foster care, group homes, or residential care that do not focus on permanency planning or return to the family home and/or duplicate the facility's discharge planning.

E. Qualifications of the Providers:

1. A child welfare-targeted case management provider must be an enrolled MA provider and possess all of the following capabilities:

a. demonstrated capacity to provide the components of child welfare-targeted case management;

b. demonstrated case management experience in coordinating and linking the community resources required by the target population;

c. administrative experience in serving the target population for whom he or she will provide services;

d. administrative capacity to ensure quality of services in accordance with state and federal requirements;

e. the ability to provide complete investigative, protective, foster care placement and related child welfare administrative services, or the ability to provide one or more of these activities through contract with the county or tribal social services;

f. a financial management system providing accurate documentation of services and costs; and

g. the capacity to document and maintain individual case records in accordance with state and federal requirements.

E. Qualifications of the Providers: (continued)

2. A case manager is an individual employed by and authorized by the child welfare-targeted case management provider to provide child welfare-targeted case management services. The case manager:

a. must be skilled in the process of identifying and assessing a wide range of children's needs;

b. must be knowledgeable about local community resources and how to use those resources for the benefit of the child; and

c. 1) must hold a bachelor's degree in social work, psychology, sociology, or a closely related field from an accredited four year college or university; or 2) hold a bachelor's degree in any field plus one year of supervised experience in the delivery of social services to children as a social worker in a public or private social services agency.

F. Freedom of Choice:

The State assures that the provision of child welfare-targeted case management services will not restrict a recipient's free choice of providers in violation of section 1902(a)(23) of the Act, except as provided for under section 1915(g)(1) of the Act.

1. Eligible recipients will have free choice of the providers of child welfare-targeted case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment:

Payment for child welfare-targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Services that are otherwise eligible for payment on a separate schedule under rules of the Department are not eligible for payment as child welfare-targeted case management services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: MINNESOTA
RELOCATION SERVICE COORDINATION SERVICES

A. **Target Group (section 1915(g) of the Act):**

Relocation service coordination services are provided to recipients residing in inpatient hospitals, nursing facilities, and intermediate care facilities for persons with ~~mental retardation~~ developmental disabilities (ICFs/~~MR~~DD) who choose to move from an institution to the community.

B. **Areas of the State in which services will be provided:**

X Entire state.

_ Only in the following geographic areas (authority section 1915 (g) (1) of the Act is invoked to provide services less than statewide): N/A

C. **Comparability of services:**

X Services are provided in accordance with section 1902(a) (10) (B) of the Act.

_ Services are not comparable in amount, duration, and scope. Authority of section 1915(g) (1) of the Act is invoked to provide services without regard to the requirements of section 1902 (a) (10) (B) of the Act.

D. **Definition of services:**

Relocation service coordination services are activities that are coordinated on an individual client basis and are designed to help recipients residing in institutions to gain access to needed

D. Definition of services: (continued)

medical, social, educational, financial, housing and other services and supports necessary to meet their needs in moving from an institution to the community.

Relocation service coordination services provided by a local social services agency; a federally recognized American Indian tribe; an entity under contract with a local social services agency or a federally recognized American Indian tribe; or a provider of mental health targeted case management under Supplement 1 include:

1. assessment of a recipient's need for medical, social, educational, financial, housing, and other services and supports;

2. development, completion, and regular review of a written individual service plan designed to help a recipient access medical, social, educational, financial, housing, and other related services and supports;

3. routine communication with the recipient and the recipient's: 1) family; 2) legal representative; 3) caregivers; 4) service providers; and 5) other relevant people identified as necessary to the development or implementation of the goals of the individual service plan;

4. coordinating referrals for, and the provision of, case management services for the recipient with appropriate service providers;

5. coordinating and monitoring the overall service delivery to ensure quality of services, appropriateness, and continued need;

6. completing and maintaining necessary documentation supporting and verifying relocation

D. Definition of services: (continued)

service coordination activities;

7. assisting recipients in order to access needed services, including travel to meet with the recipient or other relevant person necessary to develop or implement the goals of the individual service plan; and

8. coordinating with the institution discharge planner in the 180-day period before the recipient's discharge.

Relocation service coordination services provided by a private vendor include:

1. routine communication with the recipient and the recipient's: 1) family; 2) legal representative; 3) caregivers; 4) service providers; and 5) other relevant people identified as necessary to the development or implementation of the goals of the individual service plan;

2. coordinating and monitoring the overall service delivery to ensure quality of services, appropriateness, and continued need;

3. completing and maintaining necessary documentation supporting and verifying relocation service coordination activities;

4. assisting recipients in order to access needed services, including travel to meet with the recipient or other relevant person necessary to develop or implement the goals of the individual service plan; and

D. Definition of services: (continued)

5. coordinating with the institution discharge planner in the 180-day period before the recipient's discharge.

The above components of relocation service coordination must fall with the following parameters to be eligible for medical assistance payment:

1. Payment for services is limited to the last 180 consecutive days before discharge.

2. Case management services will not duplicate those provided as part of the institution's discharge plan.

E. Qualifications of providers:

A provider of relocation service coordination services must be an enrolled medical assistance provider and:

1. a local social services agency;

2. a ~~facility of the~~ federally recognized American Indian ~~Health Service~~ tribe;

3. ~~a facility owned or operated by a tribe or tribal organization and funded by Title I of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, P.L. 106-260, operating as a 638 facility;~~

~~4.~~ an entity under contract with either the local social services agency~~,~~ or a ~~facility of the~~ federally recognized American Indian ~~Health Service, or a 638 facility~~ tribe; or

5. a private vendor.

E. Qualifications of providers: (continued)

Local social services agency case managers must ~~meet the following standards~~ have:

1. a bachelor's degree or a license in a health or human services field, or comparable training and two years of experience in human services work;

2. demonstrated capacity and case management experience in providing the components of case management to coordinate and link community resources;

3. administrative capacity and case management experience in serving the target population for whom services will be provided;

4. administrative capacity to ensure quality of services in accordance with federal and state requirements;

5. a financial management system providing accurate documentation of services and costs;

6. capacity to document and maintain individual case records in accordance with federal and state requirements; and

~~7. except for private vendors, legal authority to provide complete investigative, protective, foster care placement and related child welfare administrative services, or the ability to provide one or more of these activities through contract with the county or tribal social services.~~

At a minimum, a case manager (other than a local social services agency case manager) must have:

E. Qualifications of providers: (continued)

1. a bachelor's degree or a license in a health or human services field; or comparable training and two years of experience in human services work; or been credentialed as a health professional under standards set by the governing body of a federally recognized Indian tribe and who provides services to recipients through an Indian Health Service or 638 facility;

2. met the same standards listed, above, in items 2-6 that apply to local social services agency case managers;

3. the capacity to coordinate with county administrative functions; and

4. no financial interest in the provision of out-of-home residential services to recipients of relocation service coordination services. For purposes of this item, "out-of-home residential services" means services provided out of a recipient's familial home, such as foster care and boarding care home services.

A provider of mental health targeted case management under Supplement 1 may provide relocation service coordination services.

F. Freedom of choice:

The State assures that the provision of relocation service coordination services will not restrict a recipient's freedom of choice of provider in violation of section 1902(a)(23) of the Act.

1. An eligible recipient will have free choice of the providers of targeted case management services.

E. Qualifications of providers (continued)

2. An eligible recipient will have free choice of the providers of other medical care under the State plan.

G. Payment:

Payment for relocation service coordination management services under the State plan does not duplicate payment
made to public agencies or private entities under other program authorities for this same purpose.

1. Medicaid services that are otherwise eligible for payment on a separate schedule under rules of the Department are not eligible for payment as case management services.

2. Persons receiving mental health targeted case management services under Supplement 1 are not eligible to receive the case management services described in this supplement for that month.

3. Persons receiving case management services under Supplement 1c are not eligible to receive the case management services described in this supplement for that month.

4. Persons who are receiving assertive community treatment (ACT) services under item 13.d. to this Attachment are not eligible to receive the case management services described in this supplement for that month, except for the first and last months of ACT services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: MINNESOTA

TARGETED CASE MANAGEMENT SERVICES FOR PERSONS NOT RECEIVING SERVICES PURSUANT TO A §1915(c) WAIVER WHO ARE VULNERABLE ADULTS, ADULTS WITH ~~MENTAL RETARDATION~~ DEVELOPMENTAL DISABILITIES OR RELATED CONDITIONS, OR ADULTS WITHOUT A PERMANENT RESIDENCE

A. **Target Group (section 1915 (g) of the Act):**
Targeted case management services are provided to a recipient who is at least 18 years of age, who has significant functional impairments, who does not receive services pursuant to a §1915(c) waiver who is:

1. In need of service coordination to attain or maintain living an integrated community setting; and

2. A vulnerable adult in need of adult protection, defined as an individual with a physical, mental or emotional disability:
   (a) that impairs the recipient's ability to provide adequately for the recipient's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and
   (b) because of the disability and the need for assistance, the recipient has an impaired ability to protect himself or herself from maltreatment;

3. An adult with ~~mental retardation~~ developmental disabilities or a related condition; or

4. An adult who has not had a permanent residence for at least one year or on at least four occasions in the last three years.

D. **Areas of the State in which services will be provided:**

X Entire state.

_ Only in the following geographic areas (authority section 1915{g) (1) of the Act is invoked to provide services less than statewide).

E. **Comparability of services:**

~~X~~ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration, and scope.

Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

F. **Definition of services:**

Targeted case management services are activities that are coordinated on an individual recipient basis and are designed to help recipients to gain access to needed medical, social and recreational, educational, vocational, advocacy, legal, and other services necessary to meet the recipient's needs. It does not include therapy, treatment, legal, or outreach services.

Targeted case management services include:

1. Comprehensive ~~A~~assessment and periodic reassessment of a recipient's need for targeted case management services plus any medical, educational, social or other services. These assessment activities include taking client history; identifying the individual’s needs and completing related documentation; and gathering information from other sources such as family members, medical providers, and educators, to form a complete assessment of the individual.

2. Development, completion, and regular review and revision of a written individual service plan with the recipient and the recipient's legal representative, and others identified by the recipient, designed to help a recipient to gain access to needed medical, social and

D. **Definition of services:** (continued)

3. Routine communication with the recipient and the recipient's family, legal representative, caregivers, service providers, and other relevant people identified as necessary to the development or implementation of the goals of the individual service plan.

4. Coordinating referrals for, and the provision of, targeted case management services for the recipient with appropriate service providers.

5. Coordinating and monitoring the overall service delivery to ensure quality of services, appropriateness, effectiveness, and continued need.

6. Assistance to the recipient and the recipient's legal representative to help make an informed choice of services.

7. Advocating on behalf of the recipient when service barriers are encountered, or referring the recipient and the recipient's legal representative to an independent advocate.

8. Meeting face-to-face or by interactive video that meets the requirement in state statute with the recipient at least twice a year. ~~The use of interactive video may substitute for no more than 50 percent of the required face-to-face meetings.~~

9. Completing and maintaining necessary documentation supporting and verifying targeted case management activities.

10. If a recipient is a resident or inpatient of an inpatient hospital, nursing facility, or intermediate care facility for persons with developmental disabilities (ICF/DD), coordinating with the facility discharge planner in the 180-day period before the recipient's discharge. Institutions for mental diseases (IMDs) are not included in this facility list.

The above components of targeted case management services must fall within the following parameters to be eligible for medical assistance payment:

recreational, educational, vocational, advocacy, legal and other related services. The plan must be reviewed at least annually with the recipient and the recipient's legal representative. The plan must be revised when there is a change in the recipient's status.

D. **Definition of services:**

1. ~~If a recipient is a resident or inpatient of an inpatient hospital, nursing facility, or ICF/MRID, payment for services is limited to the last 180 consecutive days before discharge~~ Target group includes individuals transition to a community setting. Case management services will be made available for 180 consecutive days of a covered stay in a medical institution.

2. Case management services will not duplicate those provided as part of the facility's discharge plan.

3. Case management services are not provided to individuals who are inmates of public institutions, or to individuals between the ages of 22 and 64 who are residing in an IMD.

E. **Qualifications of providers**:

A provider of targeted case management services must be an enrolled medical assistance provider and:

1. a local social services agency; or

2. an entity under contract with the local social services agency.

Case managers must meet the following standards:

1. Demonstrated capacity and case management experience in providing case management services to coordinate and link community resources.

2. Administrative capacity and case management experience in serving the target population for whom it will provide services.

3. Administrative capacity to ensure quality of services in accordance with federal and state requirements.

4. A financial management system providing accurate documentation of services and costs under federal and state requirements.

5. Capacity to document and maintain individual case records in accordance with federal and state requirements.

6. Coordinate with local social services agencies responsible for planning for community social services, conducting adult protective investigations, and conducting prepetition screenings for commitments.

7. Coordinate with health care providers to ensure access to necessary health care services.

8. The designated case manager must have at least a bachelor's degree in social work, special education, psychology, nursing, human services, or other fields related to the education or treatment of persons with disabilities, and one year of experience in the education or treatment of persons with disabilities.

Except for screening and service planning development services, the county board may establish procedures permitting others than those identified in item 8 to assist in providing case management services under the supervision of a case manager who meets the qualifications in item 8.

F. **Freedom of Choice**

The provision of targeted case management services will not restrict a recipient’s freedom of choice of provider in violation of 1902(a)(23) of the Act.

1. An eligible recipient will have free choice of the providers of targeted case management services.
2. An eligible recipient will have free choice of the providers of other medical care under the state plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: MINNESOTA

HOME CARE TARGETED CASE MANAGEMENT SERVICES

A. Target Group (section 1915(g) of the Act):

Home care case management services are provided to recipients not receiving any other case management services, who are receiving private duty nursing, personal care assistant services, or any of the following services provided by a home health agency:

-home health aide
-skilled nursing
-physical therapy
-occupational therapy; or
-speech therapy.

B. Areas of the State in which services will be provided:

X Entire state.

___ Only in the following geographic areas (authority section 1915(g)(1) of the Act is invoked to provide services less than statewide):

C. Comparability of services:

___ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of services:

Home care case management services are activities that are coordinated on an individual client basis and are designed to help home care service recipients to gain access to needed medical, social, educational, financial, housing and other services and supports necessary to meet their needs so that they remain in the community.

D. Definition of services: (continued)

Home care case management services include:

1. assessment of a recipient's need for medical, social, educational, financial, housing, and other services and supports;

2. development, completion, and regular review of a written individual service plan designed to help a recipient access medical, social, educational, financial, housing, and other related services and supports;

3. routine communication with the recipient and the recipient's family; legal representative; caregivers; service providers; and other relevant people identified as necessary to the development or implementation of the goals of the individual service plan;

4. coordinating referrals for, and the provision of, case management services for the recipient with appropriate service providers;

5. coordinating and monitoring the overall service delivery to ensure quality of services, appropriateness, and continued need;

6. completing and maintaining necessary documentation supporting and verifying home care case management activities;

7. assisting recipients in order to access needed services, including travel to meet with the recipient or other relevant person necessary to develop or implement the goals of the individual service plan; and

8. Meeting face-to-face with the recipient at least twice a year.

E. Qualifications of providers:

A provider of home care case management is:

1. a local social services agency;

2. a federally recognized American Indian tribe;

E. Qualifications of providers: (continued)

3. an entity under contract with either the local social services agency or a federally recognized American Indian tribe; or

4. a private entity.

A case manager of a local social services agency must have:

1. a bachelor's degree or a license in a health or human services field, or comparable training and two years of experience in human services work;

2. demonstrated capacity and case management experience in providing the components of case management to coordinate and link community resources;

3. administrative capacity and case management experience in serving the target population for whom services will be provided;

4. administrative capacity to ensure quality of services in accordance with federal and state requirements;

5. a financial management system providing accurate documentation of services and costs; and

6. capacity to document and maintain individual case records in accordance with federal and state requirements.

At a minimum, a case manager (other than a local social services agency case manager) must have:

1. a bachelor's degree or a license in a health or human services field; or comparable training and two years of experience in human services work; or, if providing services to recipients through an Indian Health Service or 638 facility, been credentialed as a health professional under standards set by the governing body of a federally recognized American Indian tribe;

2. met the same standards listed, above, in items 2-6 that apply to local social services agency case managers;

E. Qualifications of providers: (continued)

3. the capacity to coordinate with county administrative functions; and

4. no financial interest in the provision of out-of-home residential services to recipients of home care case management. For purposes of this item, "out-of-home residential services" means services provided out of a recipient's familial home, such as foster care and boarding care home services.

F. Freedom of choice:

The State assures that the provision of home care case management services will not restrict a recipient's freedom of choice of provider in violation of section 1902(a)(23) of the Act.

1. An eligible recipient will have free choice of the providers of case management services.

2. An eligible recipient will have free choice of the providers of other medical care under the State plan.

G. Payment:

- Payment for home care case management services under the State plan does not duplicate payment made to public agencies or private entities under other program authorities for this same purpose.

- Medicaid services that are otherwise eligible for payment on a separate schedule under rules of the Department are not eligible for payment as case management services.

- Persons receiving case management services under Supplements 1, 1a, 1b, or 1c to this Attachment are not eligible to receive the home care case management services described in this supplement for that month.

CONDITIONS FOR MEDICAL ASSISTANCE AND GENERAL ASSISTANCE MEDICAL CARE PAYMENT

9505.5000 APPLICABILITY.

Parts 9505.5000 to 9505.5105 establish the procedures for prior authorization of health services and the requirement of a second surgical opinion as conditions of payment to providers of health services for recipients of medical assistance, MinnesotaCare, and general assistance medical care.

These parts shall be read in conjunction with title XIX of the Social Security Act, Code of Federal Regulations, title 42, sections 430.00 to 489.57; Minnesota Statutes, sections 256.9353; 256B.01 to 256B.40; 256B.56 to 256B.71; 256D.01 to 256D.22; parts 9500.1070, subparts 1, 4, 6, 12 to 15, and 23; 9505.0170 to 9505.0475; 9505.0500 to 9505.0540; 9505.1000 to 9505.1040; and 9505.2160 to 9505.2245, and with rules adopted by the commissioner under Minnesota Statutes, sections 256.9352, 256.991, and 256D.03, subdivision 7, paragraph (b).

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03

HIST: 10 SR 842; 13 SR 1688; 19 SR 2433

9505.5005 DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 9505.5000 to 9505.5105 have the meanings given them in this part.

Subp. 1a. **Authorization number.** "Authorization number" means the number issued by:

A. the department, or an entity under contract to the department, to issue a number to a provider for the provision of a covered health service, as specified in part 9505.5010; or

B. the medical review agent that establishes that the surgical procedure requiring a second surgical opinion is medically appropriate.

Subp. 1b. **Certification number.** "Certification number" means the number issued by the medical review agent that establishes that all or part of a recipient's inpatient hospital services are medically necessary.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or an authorized designee.

Subp. 3. **Consultant.** "Consultant" means an individual who is licensed or registered according to state law or meets the credentials established by the respective professional organization in an area of health care or medical service; is employed by or under contract with the Department of Human Services; advises the department whether to approve, deny, or modify criteria for the approval of authorization requests in his or her area of expertise; advises the department on and recommends to the department policies concerning health services and whether health services meet the criteria in part 9505.5045; and performs other duties as assigned.

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

Subp. 5. **Emergency.** "Emergency" means a medical condition that, if not immediately diagnosed and treated, could cause a recipient serious physical or mental disability, continuation of severe pain, or death.

Subp. 6. **Fair hearing.** "Fair hearing" means an administrative proceeding under Minnesota Statutes, section 256.045 and as provided in part 9505.5105, to examine facts concerning the matter in dispute and to advise the commissioner whether the department's decision to reduce or deny benefits was correct.

Subp. 7. **General assistance medical care or GAMC.** "General assistance medical care" or "GAMC" means the health services provided to a recipient under the general assistance medical care program according to Minnesota Statutes, chapter 256D.

Subp. 8. **Health services.** "Health services" means the services and supplies furnished to a recipient by a provider as defined in subpart 16.

Subp. 9. **Investigative.** "Investigative" means:

A. A health service procedure which has progressed to limited human application and trial, which lacks wide recognition as a proven and effective procedure in clinical medicine as determined by the National Blue Cross and Blue Shield Association Medical Advisory Committee, and utilized by Blue Cross and Blue Shield of Minnesota in the administration of their program.

B. A drug or device that the United States Food and Drug Administration has not yet declared safe and effective for the use prescribed. For purposes of this definition, drugs and devices shall be those identified in the Food and Drug Act.

Subp. 10. **Local agency.** "Local agency" means a county or a multicounty agency that is authorized under Minnesota Statutes as the agency responsible for the administration of the medical assistance and general assistance medical care programs.

Subp. 11. **Local trade area.** "Local trade area" means the geographic area surrounding the recipient's residence which is commonly used by other persons in the same area to obtain necessary goods and services.

Subp. 12. **Medical assistance or MA.** "Medical assistance" or "MA" means the Medicaid program established by title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

Subp. 12a. **Medical appropriateness or medically appropriate.** "Medical appropriateness" or "medically appropriate" refers to a determination, by a medical review agent or the department, that the recipient's need for a surgical procedure requiring a second surgical opinion meets the criteria in part 9505.0540 or that a second or third surgical opinion has substantiated the need for the procedure.

Subp. 12b. **Medical review agent.** "Medical review agent" means the representative of the department who is authorized in parts 9505.0500 to 9505.0540 to determine the medical appropriateness of procedures requiring second surgical opinions.

Subp. 13. **Medicare.** "Medicare" means the health insurance program for the aged and disabled established by title XVIII of the Social Security Act.

Subp. 13a. **MinnesotaCare.** "MinnesotaCare" means the program established under Minnesota Statutes, sections 256.9351 to 256.9361.

Subp. 14. **Physician.** "Physician" means a person licensed to provide services within the scope of his or her profession as defined in Minnesota Statutes, chapter 147. For purposes of the second surgical opinion requirement in parts 9505.5035 to 9505.5100, "physician" shall also mean:

A. a person licensed to provide dental services within the scope of his or her profession as defined in Minnesota Statutes, section 150A.06, subdivision 1; or

B. a person who is qualified to render an opinion regarding the surgical procedure as evidenced by his or her certification or eligibility for certification from the appropriate specialty board if, according to the community standard, such certification or eligibility for certification is required of persons performing the surgical procedure in question.

Subp. 15. **Prior authorization.** "Prior authorization" means the written approval and issuance of an authorization number by the department, or by an entity under contract to the department, to a provider for the provision of a covered health service, as specified in part 9505.5010, prior to payment for that service.

Subp. 16. **Provider.** "Provider" means an individual or organization under an agreement with the department to furnish health services to persons eligible for the medical assistance, general assistance medical care, or MinnesotaCare programs.

Subp. 17. **Recipient.** "Recipient" means a person who is eligible for and receiving benefits from the medical assistance, general assistance medical care, or MinnesotaCare programs.

Subp. 18. **Referee.** "Referee" means an individual who conducts fair hearings under Minnesota Statutes, section 256.045 and recommends orders to the commissioner.

Subp. 18a. **Second opinion or second surgical opinion.** "Second opinion" or "second surgical opinion" means the determination by the medical review agent under part 9505.5050, subpart 1, or by a second physician under part 9505.5050, subpart 2, that a surgical procedure requiring a second surgical opinion is or is not medically appropriate.

Subp. 18b. **Third opinion or third surgical opinion.** "Third opinion" or "third surgical opinion" means the determination by a third physician under part 9505.5050, subpart 3, that a surgical procedure requiring a second surgical opinion is or is not medically appropriate.

Subp. 19. **Working days.** "Working days" means Monday through Friday, excluding state recognized legal holidays.

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03

HIST: 10 SR 842; 13 SR 1688; 19 SR 2433

9505.5010 PRIOR AUTHORIZATION REQUIREMENT.

Subpart 1. **Provider requirements.** A provider shall obtain prior authorization as a condition of payment under the medical assistance, general assistance medical care, and MinnesotaCare programs for health services designated under parts 9505.0170 to 9505.0475 and 9505.5025; and Minnesota Statutes, section 256B.0625, subdivision 25. The provider of the health service shall submit the request on form DHS-3065 or DHS-3066, or the American Dental Association (ADA) form as required in subpart 3, and shall submit materials, reports, progress notes, admission histories, and other information that substantiates that the service is medically necessary to treat the recipient. If the provider obtains prior authorization before the health service is provided but before payment, the provider shall be assured payment at the authorized level after the recipient has received the service. If a provider requests prior authorization after the service has been provided but before payment, the provider shall be assured of payment only if prior authorization is given. Additionally, prior authorization shall assure the provider payment for the approved health service only if the service is given during a time the person is a recipient and the provider meets all requirements of the medical assistance, general assistance medical care, or MinnesotaCare programs.

Subp. 2. **Repealed, 19 SR 2433**

Subp. 3. **Submission of forms.** The provider shall submit to the department a request for prior authorization on form DHS-3065 or DHS-3066, or the American Dental Association (ADA) form, which has been completed according to instructions in the Minnesota Health Care Programs Provider Manual, and other information necessary to address the criteria in part 9505.5030. The provider shall bear the burden of establishing compliance with the criteria in part 9505.5030 and shall submit information which demonstrates that the criteria in part 9505.5030 are met. The provider who administers or supervises the recipient's care shall personally review and sign the form and any attached documentation.

Subp. 4. **Consequences of failure to comply.** A provider who furnishes health services without obtaining prior authorization under parts 9505.5010 to 9505.5030 shall be denied payment. A physician, hospital, or other provider who is denied payment because of failure to comply with parts 9505.5010 to 9505.5030 shall not seek payment from the recipient and the recipient shall not be liable for payment of the service for which the provider is denied payment due to lack of prior authorization.

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03

HIST: 10 SR 842; 13 SR 1688; 16 SR 2102; 19 SR 2433

9505.5015 Repealed, 19 SR 2433

9505.5020 DEPARTMENT RESPONSIBILITIES.

Subpart 1. **Notification requirements.** If the information submitted by the provider does not meet the requirements of part 9505.5030, the department shall notify the provider of what is necessary to complete the request. The department shall send the provider, within 30 working days of receipt of all the information required in part 9505.5010, a notice of the action taken on the request for prior authorization. If the prior authorization request is denied, the department shall send the recipient within the same time period a copy of the notice sent to the provider and a statement of the recipient's right to appeal as provided in Minnesota Statutes, section 256.045.

Subp. 2. **Retention of information submitted by provider.** The department shall have the right to retain information submitted to the department by the provider in accordance with part 9505.5010.

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03

HIST: 10 SR 842; 19 SR 2433

9505.5025 HEALTH SERVICES PROVIDED OUTSIDE OF MINNESOTA.

Prior authorization for health services to be provided outside of Minnesota under part 9505.0215 must be obtained before the service is provided. A health service that is provided to a Minnesota resident outside of Minnesota but within the recipient's local trade area and that would not require prior authorization if it were provided to a Minnesota resident within Minnesota shall be exempt from the prior authorization requirement.

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03

HIST: 10 SR 842; 19 SR 2433

9505.5030 CRITERIA FOR APPROVAL OF PRIOR AUTHORIZATION REQUEST.

A request for prior authorization of a health service shall be evaluated by consultants using the criteria given in items A to F. A health service meeting the criteria in this part shall be approved, if the health service is otherwise a covered service under the MA or GAMC programs. The health service must:

A. be medically necessary as determined by prevailing medical community standards or customary practice and usage;

B. be appropriate and effective to the medical needs of the recipient;

C. be timely, considering the nature and present state of the recipient's medical condition;

D. be furnished by a provider with appropriate credentials;

E. be the least expensive appropriate alternative health service available; and

F. represent an effective and appropriate use of program funds.

STAT AUTH: MS s 256.991

HIST: 10 SR 842

9505.5035 SURGICAL PROCEDURES REQUIRING SECOND OPINION.

Subpart 1. **General requirements.** Except as provided in part 9505.5040, second surgical opinions shall be required for medical assistance and general assistance medical care recipients for inpatient and outpatient elective surgical procedures according to the list published in the State Register under Minnesota Statutes, section 256B.0625, subdivisions 1 and 4. Publication shall occur in the last issue of the State Register for the month of October if there has been a revision in the list since the last October. In addition, the department shall publish any revision of the list at least 45 days before the effective date if the revision imposes a second surgical opinion requirement. The department shall send each provider a copy of the published list or a revision of the published list.

Subp. 2. **Requirements prior to eligibility determination.** The requirements of parts 9505.5035 to 9505.5100 shall apply to individuals who have applied for MA or GAMC, but whose applications have not yet been approved or denied at the time the surgical procedure is performed.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; L 1988 c 689 art 2 s 268; 13 SR 1688

9505.5040 EXEMPTIONS TO SECOND SURGICAL OPINION REQUIREMENTS.

If the requirements of part 9505.5096 are met and the surgical procedure is medically appropriate as defined in part 9505.5005, subpart 12a, a second surgical opinion is not required in the circumstances set out in items A to F:

A. The surgical procedure is approved for reimbursement by Medicare.

B. The surgical procedure is a consequence of, or a customary and accepted practice as an incident to, a more major surgical procedure.

C. The procedure is an emergency. For an emergency, the physician shall submit substantiating documentation such as medical reports, progress notes, an admission history, or any other pertinent information necessary to substantiate the characterization of the surgical procedure as an emergency.

D. A visit to another physician to obtain a second opinion requires travel outside the local trade area.

E. The recipient has good cause for not obtaining a second opinion. Good cause refers to circumstances beyond the recipient's control. Examples of good cause include illness of the recipient, illness of a family member requiring the presence of the recipient, weather conditions that prohibit safe travel, or the unavailability of transportation.

F. The surgical procedure is performed before the individual's date of application for MA or GAMC, and retroactive eligibility was extended to cover the period of time during which the surgical procedure was performed.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; 13 SR 1688

9505.5045 CRITERIA TO DETERMINE WHEN SECOND OPINION IS REQUIRED.

The commissioner shall use the criteria in items A to E to determine which surgical procedures shall be subject to the second surgical opinion requirement.

A. Authoritative medical literature identifies the surgical procedure as being overutilized.

B. The surgical procedure is shown to be utilized to a greater degree within the Medicaid population than in the non-Medicaid population.

C. The utilization or cost of a surgical procedure falls within the top ten percent of all surgical procedures reimbursed under the MA and GAMC programs.

D. Alternative methods of treatment which are less intrusive are available.

E. The surgical procedure has at least a five percent rate of failure to obtain the requisite two physician's approvals, as determined by the Minnesota Medical Assistance Second Surgical Opinion Program or a similar second surgical opinion program.

STAT AUTH: MS s 256.991
HIST: 10 SR 842

9505.5050 SECOND AND THIRD SURGICAL OPINIONS.

Subpart 1. **Second surgical opinion by medical review agent.** Except as provided in subpart 2, a second surgical opinion must be obtained from the medical review agent as specified in parts 9505.0520, subparts 6 and 8, and 9505.0540.

Subp. 2. **Second surgical opinion by a second physician.** If the department does not have a contract with the medical review agent to provide a second surgical opinion, a second surgical opinion must be obtained from a second physician.

Subp. 3. **Third surgical opinion.** If a second surgical opinion obtained under subpart 1 or 2 fails to substantiate the initial surgical opinion and the recipient still wants the surgery, a third surgical opinion shall be obtained from a third physician. No opinion beyond the third opinion shall be considered in meeting the requirements of this part. The cost of an opinion beyond the third opinion shall not be reimbursed under the medical assistance or general assistance medical care program.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)
HIST: 10 SR 842; 13 SR 1688

9505.5055 SECOND OR THIRD OPINION BY A PHYSICIAN.

Subpart 1. **Duties of physician offering to provide the surgical service.** If the recipient requires the opinion of a second physician under part 9505.5050, subpart 2, or if the medical review agent or the second physician determines that the surgical procedure requiring a second surgical opinion is medically inappropriate and the recipient needs a third opinion

under part 9505.5050, subpart 3, the physician offering to provide the surgical service shall provide to the recipient in need of the second or third surgical opinion the names of at least two other physicians who are qualified to render the surgical opinion, or the name of an appropriate medical referral resource service, and information about the consequences of failing to obtain a second or third opinion. The physician offering the surgical service shall ensure that the required second opinion or third opinion is obtained.

Subp. 2. **Qualifications of physician offering second or third opinions.** The physician offering the surgical service and the physician named to render a second or third opinion or the medical referral resource service shall have no direct shared financial interest or referral relationship resulting in a shared financial gain. The physician who gives a second or third opinion must be a provider and must meet the criteria on experience in treating and diagnosing the condition that requires a second or third surgical opinion as published in the State Register under part 9505.5035.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)
HIST: 10 SR 842; 10 SR 1688

9505.5060 PENALTIES.

The penalties for failure to comply with parts 9505.5000 to 9505.5100 shall be imposed in accordance with parts 9505.2160 to 9505.2245 in addition to parts 9505.0145, 9505.0465, and 9505.0475.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)
HIST: 10 SR 842; 13 SR 1688

9505.5065 REIMBURSEMENT OF COST OF SECOND AND THIRD SURGICAL OPINIONS.

Reimbursement of the cost of a second or third surgical opinion under the medical assistance and general assistance medical care programs shall be permitted up to the allowable fee maximums as maintained by the department. When the physician who provides the second or third surgical opinion also performs the surgery, reimbursement for the surgery shall be denied.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)
HIST: 10 SR 842; 13 SR 1688

9505.5070 TIME LIMITS; SECOND AND THIRD OPINIONS; SURGERY.

The second surgical opinion from the medical review agent or a second physician shall be obtained within 90 days of the date of the initial opinion. The surgical opinion from a third physician, if required, shall be obtained within 45 days of the date of the opinion of the medical review agent or the second physician. Approved surgery, if not performed within 180 days of the initial opinion, and if still requested by the recipient, shall require repetition of the second surgical opinion process as described in this part.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; 13 SR 1688

9505.5075 PHYSICIAN RESPONSIBILITY.

The physician who provides a second or third opinion shall indicate his or her approval or disapproval of the requested surgical procedure, on a form supplied by the department. The completed form shall contain all the information considered necessary by the commissioner to substantiate the second opinion, shall be personally signed by each physician providing an opinion, and shall be attached to a completed and signed prior authorization form. The completed form must be returned to the physician offering to provide the surgical service and must be retained and made available, for at least five years, by the physician to the department as provided in part 9505.5080, or, on request, to a medical review agent under contract to the department.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; 13 SR 1688

9505.5080 FAILURE TO OBTAIN REQUIRED OPINIONS.

Subpart 1. **Opinion of medical review agent.** Failure of the physician who offers to provide a surgical procedure requiring a second opinion to obtain a required surgical opinion from the medical review agent shall result in denial of reimbursement for all costs, direct and indirect, associated with the surgery, including costs attributable to other providers and hospitals.

Subp. 2. **Opinion of second or third physician.** Failure of a physician who offers to provide a surgical procedure requiring a second opinion to obtain the required surgical opinion from a second or third physician shall result in denial of reimbursement for all costs, direct and indirect, associated with the surgery, including costs attributable to other providers and hospitals except the providers who rendered the second or third surgical opinion.

Subp. 3. **Submission of completed form to department.** If the second or third opinion by a physician does not substantiate the need for the surgical procedure and if the department does not have a contract with a medical review agent, then the physician offering to provide the surgical procedure shall submit the completed form to the department within 135 days of the date of the first opinion. Failure to comply with this subpart may result in termination of the provider's agreement with the department.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; 13 SR 1688

9505.5085 PROHIBITION OF PAYMENT REQUEST.

A physician, hospital, or other provider who is denied reimbursement because of failure to comply with parts 9505.5035 to 9505.5100 shall not seek payment from the recipient of the service and the recipient shall not be liable for payment for

the service for which reimbursement was denied.

STAT AUTH: MS s 256.991

HIST: 10 SR 842

9505.5090 MEDICAL REVIEW AGENT AND DEPARTMENT RESPONSIBILITY.

Subpart 1. **Medical review agent responsibility.** Except as provided in subpart 2, if the medical review agent agrees that the requested surgical procedure is medically appropriate, the medical review agent shall certify that the requirements of this part are met, shall assign an authorization number within one working day of the medical review agent's receipt of the information, and shall issue a hospital admission certification number if the procedure requires inpatient hospital admission.

If the third physician, consulted according to part 9505.5050, subpart 3, agrees with the physician offering to provide the surgical service that the requested surgical procedure is medically appropriate, the medical review agent shall certify that the requirements of this part are met, shall assign an authorization number within one working day of the medical review agent's receipt of the necessary information and forms, and shall issue a hospital certification number.

If the third physician agrees with the second opinion provided by the medical review agent that the requested surgical procedure is not medically appropriate, then the medical review agent shall deny an authorization number and a certification number and the department shall deny authorization of reimbursement for the requested surgical procedure. The medical review agent shall send the recipient a copy of the notice denying authorization for the surgery and a statement of the recipient's right to appeal as provided in Minnesota Statutes, section 256.045.

Subp. 2. **If no medical review agent.** The department shall assign or deny an authorization number when the department does not have a contract with a medical review agent to determine the medical appropriateness of procedures requiring second surgical opinions.

If two of the three physicians agree that the requested surgical procedure is medically appropriate, the department shall certify that the requirements of this part are met and shall assign an authorization number within 30 working days of the department's receipt of the necessary information and forms.

If two of the three physicians agree that the requested surgical procedure is inappropriate, then the department shall deny authorization of reimbursement for the requested surgical procedure. The department shall send the recipient a copy of the notice denying authorization for the surgery and a statement of the recipient's right to appeal as provided in Minnesota Statutes, section 256.045.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)

HIST: 10 SR 842; 13 SR 1688

9505.5095 **Repealed, 13 SR 1688**

9505.5096 REQUEST FOR EXEMPTION FROM SECOND SURGICAL OPINION.

Subpart 1. **Request for exemption; general.** A provider who believes a surgical procedure is exempt under part 9505.5040 from the second or third opinion requirement shall request approval of the exemption from the medical review agent or the department before carrying out the surgical procedure, except for exemptions under part 9505.5040, items B, C, and F, which may be requested after performing the surgical procedure.

Subp. 2. **Request for exemption before carrying out surgical procedure.** A provider shall request approval of the exemption either under item A or B.

A. If the department has a contract with a medical review agent, the provider shall call the medical review agent and provide the information required in parts 9505.5000 to 9505.5030.

B. If the department does not have a contract with a medical review agent, the provider shall submit the request to the department according to the prior authorization procedures in part 9505.5010.

Subp. 3. **Request for exemption after performing the surgical procedure.** If a provider chooses to carry out the surgical procedure before requesting approval of the exemption, the provider shall request approval of the exemption under item A or B.

A. If the department has a contract with a medical review agent, the provider shall submit to the medical review agent the medical records related to the recipient's medical condition, diagnosis, and treatment.

B. If the department does not have a contract with a medical review agent, the provider shall submit the request to the department according to the procedures in part 9505.5015.

Subp. 4. **Retroactive eligibility.** A hospital may seek an authorization number for a person found retroactively eligible for medical assistance or general assistance medical care program benefits after the date of admission. The hospital shall inform the physician offering to provide the surgical service of the authorization number of a retroactively eligible recipient. The physician offering to provide the surgical service and the hospital shall not seek an authorization number for a person whose application for the medical assistance or general assistance medical care program is pending. The medical review agent may require the hospital to submit, at its own expense, a copy of the complete medical record to substantiate the medical appropriateness of the surgical procedure. Failure to submit a requested record within 30 days of the request shall result in denial of the authorization number.

Subp. 5. **Documentation required.** A provider who believes a surgical procedure is exempt from the second and third opinion requirement under part 9505.5040 must submit supporting documentation with the request for exemption. If the provider requests approval of the exemption before performing the procedure, the department or medical review agent, as

appropriate, may withhold approval of the exemption until the provider has submitted the documentation.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)
HIST: 13 SR 1688

9505.5100 INDEPENDENT PHYSICIAN EVALUATION.

The commissioner shall have the right to order an independent evaluation by a physician selected by the recipient and approved by the commissioner when the commissioner has reason to believe, based on parts 9505.2160 to 9505.2245, that the requested surgical procedure is not medically appropriate. If the recipient needs assistance locating an appropriate physician, the services of the local county medical society, or any other physician referral resource may be used. If the selected physician determines the procedure is not medically appropriate, the commissioner shall deny authorization.

STAT AUTH: MS s 256.991; 256D.03 subd 7 para (b)
HIST: 10 SR 842; 13 SR 1688

9505.5105 FAIR HEARINGS AND APPEALS.

Subpart 1. **Appealable actions.** A recipient may appeal any of the following department actions:

A. the department has failed to act with reasonable promptness on a request for prior authorization under parts 9505.5000 to 9505.5030 or on an authorization request under the second surgical opinion program, as established under part 9505.5090;

B. the department has denied a request for prior authorization under parts 9505.5000 to 9505.5030;

C. the department has denied an authorization request under the second surgical opinion program; or

D. the department has proposed a reduction in service as an alternative to authorization of a proposed service for which prior authorization under parts 9505.5000 to 9505.5030 was requested.

Subp. 2. **No right to appeal.** The right to appeal shall not apply to the list of surgical procedures established according to Minnesota Statutes, sections 256B.02, subdivision 8 and 256B.0625.

Subp. 3. **Request for fair hearing.** When a recipient requests assistance from a local agency in filing an appeal with the department, the local agency shall provide the assistance.

The request for a hearing must be submitted in writing by the recipient to the appeals unit of the department. The request must be filed either:

A. within 30 days of the date notice of denial of the request for prior authorization under parts 9505.5000 to 9505.5030 or request for authorization of a surgical procedure was received; or

B. no later than 90 days from the date notice of denial was received if the appeals referee finds there was good cause for the delay.

Subp. 4. **Fair hearing.** A referee shall conduct the hearing according to Minnesota Statutes, section 256.045, subdivision 4.

Subp. 5. **Commissioner's ruling.** Within 90 days of the date of receipt of the recipient's request for a hearing, the commissioner shall make a ruling to uphold, reverse, or modify the action or decision of the department or the medical review agent. The commissioner's ruling shall be binding upon the department and the recipient unless a request for judicial review is filed pursuant to Minnesota Statutes, section 256.045, subdivision 7.

STAT AUTH: MS s 256.9352; 256.991; 256B.04; 256D.03

HIST: 10 SR 842; L 1988 c 689 art 2 s 268; 13 SR 1688; 19 SR 2433

STATE: MINNESOTA
Effective: July 1, 2005
TN: 05-03
Approved: MAY 18 2006
Supersedes: 96-08

Supplement 4 to Attachment 3.1-B

ALTERNATIVE HEALTH CARE PLANS

Minnesota enrolls recipients in ~~prepaid health plans~~ managed care organizations with which the State Medicaid agency contracts under the authority of §1903(m) and §1915(b) of the Act, and a §1115 waiver. Recipients are assured of access to services and of adequate quality through these contracts ~~which~~ that meet the requirements of 42 CFR §§434 and 438. The contracts require ~~prepaid health plans~~ managed care organizations to provide to enrollees the comprehensive health care services covered in Attachments 3.1-A and 3.1-B, except for the services listed in Attachment 3.1-F, item L, but ~~prepaid health plans~~ managed care organizations may also provide health care services in addition to the health care services in Attachments 3.1-A and 3.1-B when, in the judgment of the ~~prepaid health plans~~ managed care organizations, the provision of such services is medically necessary. The contracts also require the ~~prepaid health plans~~ managed care organizations to establish a quality assurance system under ~~CFR §434.34~~ 42 CFR §438, Subpart D.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE MEDICALLY NEEDY

PACE SERVICES

_x_ The State of Minnesota has not entered into any valid program agreements with a PACE provider and the Secretary of Health and Human Services.

___ The State of Minnesota has entered into a valid program agreement(s) with a PACE provider(s) and the Secretary, as follows:

Name of PACE provider: _____

Service area: _____

Maximum number of individuals to be enrolled: _____

Medical assistance covers medically necessary services and consultations delivered via ~~telemedicine~~ telehealth when performed by:

- a licensed or state registered health care provider;
- a mental health practitioner working under the supervision of a mental health professional;
- a certified community health worker;
- an alcohol and drug counselor;
- recovery peers;
- substance abuse disorder treatment coordinators
- mental health certified peer specialists and certified family peer specialists;
- rehabilitation workers in ARMHS;
- mental health behavioral aides operating in a CTSS program;
- federally qualified health centers and rural health centers including Indian Health providers; and
- providers qualified in accordance with par. 13(d) of Attachment 3.1- A to provide a comprehensive assessment for substance use disorder services, in the same manner as if the service or consultation was delivered in person.

Telehealth means the delivery of health care services or consultations through the use of real time two-way interactive video and visual or audio-only communication to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. ~~Telemedicine~~ Telehealth includes the application of secure video conferencing, store and forward technology, and synchronous interactions between a ~~is the delivery of health care services while the~~ patient ~~is~~ at an originating site and ~~the~~ a health care provider ~~is~~ at a distant site. A communication between health care providers, or a health care provider and a patient that consists solely of mail, e-mail, or facsimile does not constitute ~~telemedicine~~ telehealth ~~services~~. ~~Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing, or store-and-forward technology, or via telephone when social distancing or quarantine is necessary either for the provider or the patient and video communication is not feasible.~~ Providers utilizing ~~telemedicine~~ telehealth must comply with criteria established by the Minnesota Department of Human Services in order to demonstrate that a quality assurance process and established protocols for patient safety have been addressed before, during, and after a particular service is delivered via telehealth~~telemedicine~~.

State of Minnesota

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(b)(1) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1905(a)(29)___X__MAT as described and limited in Supplement__7__ to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies the medical and remedial services provided to the medically needy.

1905(a)(29) Medication-Assisted Treatment (MAT)

i. General Assurance

MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020, and ending September 30, 2025.

ii. Assurances

a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

c. The state assures coverage for all formulations of MAT drugs and biologicals for OUD that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

iii. Service Package

From October 1, 2020, through September 30, 2025, the state assures that MAT to treat OUD as defined at section 1905(ee)(1) of the Social Security Act (the Act) is covered exclusively under section 1905(a)(29) of the Act.

a. The state covers the following counseling services and behavioral health therapies as part of MAT.

Individual and Group Therapy

This service assists the beneficiary with achieving the goals developed in an individual opioid use disorder treatment plan with the establishment of an individual recovery plan by identifying problems and implementing strategies to address, minimize, or reduce the inappropriate use and effects of chemicals through a combination of skills therapy, counseling, and service coordination. Therapy may also include consultation with relatives, guardians, close friends, and other treatment providers. Participation of non-Medicaid eligible persons is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

1905(a)(29) Medication-Assisted Treatment (MAT) (continued)

b. The following practitioners are qualified to provide this service within their scope of practice:

- Licensed alcohol and drug counselors;
- counselor supervisors of licensed alcohol and drug counselors;
- licensed social workers
- licensed marriage and family therapists; and
- licensed professional counselors.

c. The following is a brief summary of qualifications for each practitioner identified above:

Counselor supervisors of licensed alcohol and drug counselors must have three years of work experience as a licensed alcohol and drug counselor. Licensed professional counselors must have a master's degree which included 120 hours of a specified course of study in addition studies with 440 hours of post-degree supervised experience in the provision of alcohol and drug counseling.

Counseling and behavioral health therapies delivered as part of medication assisted treatment services are provided according to an individual recipient's treatment plan by an entity licensed by the Minnesota Department of Human Services to provide substance use disorder services or by a licensed professional in private practice.

1905(a)(29) Medication-Assisted Treatment (MAT) (continued)

iv. **Utilization Controls**

__X___The state has drug utilization controls in place. (Check each of the following that apply)

___X__ Generic first policy
___X__ Preferred drug lists
___X_ Clinical criteria
___X__ Quantity limits
_____ The state does not have drug utilization controls in place.

v. **Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.**

There are no limitations on the amount, duration, or scope of MAT counseling and behavioral therapies. Oral buprenorphine is subject to quantity limits, and certain products and brands are included on the state's Preferred Drug List. Injectable and implantable buprenorphine are covered through the medical benefit with prior authorization.

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on October 24, 2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid state plan benefit for the period beginning October 1, 2020, and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 60). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Minnesota Department of Human Services

MEDICAID PROGRAM: REQUIREMENTS RELATING TO COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation(s)	Provision(s)
~~§1935(d)(1)~~	~~Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.~~

6/20/13

STANDARDS AND METHODS OF ASSURING HIGH QUALITY OF CARE

The Department has developed a written ~~health~~ managed care quality strategy ~~improvement system that is~~ consistent with federal ~~requirements under Title XIX and~~ regulations at 42 CFR ~~§434.34~~ §§438.202 and 438.204. The State's ~~health care~~ quality ~~improvement system~~ strategy includes ~~a mechanism~~ mechanisms designed to ~~hold managed care organizations accountable for monitoring, evaluating~~ monitor and ~~taking action to improve the health care delivered or arranged for under the~~ evaluate contracted managed care organizations' ~~contract~~ (MCOs') compliance with ~~the~~ federal and state standards for the quality of health care provided to enrollees.

The quality strategy is reviewed annually and updated as necessary, and it includes recommendations provided by an independent External Quality Review Organization (EQRO). The EQRO annually conducts a review of each MCO and reports on the quality outcomes and timeliness of, and access to, the services covered under each MCO contract.

~~To accomplish its quality measurement and improvement activities, the State works with the Department's Quality Advisory Committee composed of representatives from the health plans, the Minnesota Department of Health, and the county human service agencies. Quality assurance program standards are also included in health plan contracts, and compliance is monitored through the interagency agreement by the Minnesota Department of Health.~~

~~In addition, the State monitors the quality of care provided to health plan enrollees through yearly contracts with an external quality review organization that performs an independent review of conditions of interest selected by the Department and the Advisory Committee. This requirement may be satisfied by participation in the consumer satisfaction survey developed by the Minnesota Health Data Institute to measure health plan enrollee satisfaction with their health care. The State requires health plans to administer an annual member satisfaction survey to assess the level of satisfaction with the health care received through their health plan.~~

The scope of the quality strategy includes the federally mandated external quality review activities in 42 CFR §438.358(b): 1) determining a MCO's compliance with federal Medicaid managed care regulations; 2) validation of performance measures produced by a MCO; and 3) validation of performance improvement projects undertaken by a MCO.

An annual consumer satisfaction survey is also conducted to obtain enrollee feedback on services provided.

3.1-C-2. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State provides benchmark benefits:

X Provided

☐ **Not Provided**

States can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying "Plan A" was checked then the remainder of the pre-print that would appear would be specific only to "Plan A". If "Plan B" was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State and would correlate to "Plan B" only.)

X	**Title of Alternative Benefit Plan A: Medicaid State Plan**
☐	**Title of Alternative Benefit Plan B**
☐	**Add Titles of additional Alternative Benefit Plans as needed**

1. Populations and geographic area covered

☐ **a) Individuals eligible under groups other than the early option group authorized under section 1902(a)(10)(A)(i)(VIII) and 1902(k)(2)**

The State will provide the benefit package to the following populations:

☐ (i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in an alternative benefit plan to obtain medical assistance.

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State plan under section 1902(a)(10(A)(i) of the Act.
- An individual who qualifies for medical assistance under the State plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.
- An individual entitled to benefits under any part of Medicare.
- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.
- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.
- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State's definition of individuals who are medically frail or otherwise have special medical needs should include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.
- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)C) of the Act.
- An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.
- A parent or caretaker relative whom the State is required to cover under section 1931 of the Act.
- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.
- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.
- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.
- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the State will require to enroll in the alternative benefit plan;
- Each eligibility group the State will allow to voluntarily enroll in the alternative benefit plan;
- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
		Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance		
		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)		
		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		
		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		
		Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group:		
		Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)A)(ii)(IX)		
		Optional categorically needy poverty level infants eligible under 1902(a)(10)A)(ii)(IX)		
		Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)		
		Medicaid expansion/optional targeted low-income children eligible under 1902(a)10)(A)(ii)(XIV)		

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
		Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group:		

☐ (ii) The following populations will be given the option to voluntarily enroll in an alternative benefit plan. Please indicate in the chart below:

- Each population the State will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included population (e.g., income standard).
- Specify the geographic area in which each population will be covered.

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	Mandatory categorically needy low-income parents eligible under 1931 of the Act		
	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):		
	Individuals qualifying for Medicaid on the basis of blindness		
	Individuals qualifying for Medicaid on the basis of disability		
	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(vii)		
	Institutionalized individuals assessed a patient contribution towards the cost of care		
	Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)		
	Disabled children eligible under the TEFRA option - section 1902(e)(3)		
	Medically frail and individuals with special medical needs		
	Children receiving foster care or adoption assistance under title IV-E of the Act		
	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)		

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)		
	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)		

Limited Services Individuals

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

☐ (iii) For optional populations/individuals (checked above in Ia. & Ib.), describe in the text box below the manner in which the State will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State plan.

X b) **Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)**

Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, States may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

(i) The State has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Specify whether the benchmark will cover these individuals statewide or otherwise.

Voluntary enrollment is not applicable because the benchmark is identical to the state plan benefits. The benchmark will cover individuals statewide.

(ii) For optional populations/individuals [checked above in b(i)], describe in the text box below the manner in which the State will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State plan.

2. Description of the Benefits

X The State will provide the following alternative benefit package (check the one that applies), a)

☐ Benchmark Benefits

☐ **FEHBP-equivalent Health Insurance Coverage** - The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(1) of Title 5, United States Code.

☐ **State Employee Coverage** - A health benefits coverage plan that is offered and generally available to State employees within the State involved.

In the text box below please provide either a World Wide Web URL (Uniform Resource Locator) link to the State's Employee Benefit Package or insert a copy of the entire State Employee Benefit Package.

☐ **Coverage Offered Through a Commercial Health Maintenance Organization (HMO)** - The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State involved.

In the text box below please provide either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

X **Secretary-approved Coverage** - Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State plan or to services in any of the three Benchmark plans above.

All benefits and applicable limitations are provided, as outlined by the Minnesota State Plan under Title XIX of the Social Security Act, Medical Assistance Program in Section 3 - Services: General Provisions and Attachments 3.1-A and 3.1-B.

b) ☐ Benchmark-Equivalent Benefits.

Specify which benchmark plan or plans this benefit package is equivalent to:

(i) Inclusion of Required Services - The State assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

☐ Inpatient and outpatient hospital services; n

☐ Physicians' surgical and medical services; Pl

☐ Laboratory and x-ray services;

☐ Coverage of prescription drugs

☐ Mental health services

☐ Well-baby and well-child care services as defined by the State, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;

☐ Emergency services

☐ Family planning services and supplies

(ii) ☐ Additional services

Insert below a full description of the benefits in the plan including any limitations.

(iii) ☐ The State assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;
- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;
- Applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- Takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based
on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

Insert a copy of the report.

(iv) ☐ The State assures that if the benchmark plan used by the State for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following two categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State:

- Vision services, and/or
- Hearings services

In the text box below provide a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c) ☐ Additional Benefits

Insert a full description of the additional benefits including any limitations.

3. Service Delivery System

Check all that apply.

☐ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(aX25) and 1905(t). (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR §438, 1903(m), and 1932).

☐ The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR §438.

☐ The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

X The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.)

The alternative benefit plan will be provided through a combination of fee-for-service reimbursement and managed care, as outlined in Attachment 3.1-F.

4. Employer Sponsored Insurance

☐ The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

☐ The State assures EPSDT services will be provided to individuals under 21 years old who are covered under the State Plan under section 1902(aX10XA).

☐ Through Benchmark only

☐ As an Additional benefit under section 1937 of the Act

X Not applicable. There are no children in this group.

X The State assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(aX2).

X The State assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

Emergency and non-emergency transportation services are provided according to Section 3.1(c)(1) and Attachment 3.1-D for fee-for-service recipients and through managed care plans for managed care enrollees.

X The State assures that effective January 1, 2014 any benchmark benefit plan provides at least essential health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

X The State assures that family planning services and supplies are covered for individuals of child-bearing age.

6. Economy and Efficiency of Plans

X The State assures that alternative benefit coverage is provided in accordance with Federal upper payment limits and procurement requirements.

7. Compliance with the Law

X The State will continue to comply with all other provisions of the Social Security Act in the administration of the State plan under this title.

8. Implementation Date

X The State will implement this State Plan amendment on March 1, 2011.

METHODS OF PROVIDING TRANSPORTATION

~~42 CFR 431.53~~

Non-emergency medical transportation includes coverage for transportation and other related travel services determined to be necessary to enable a recipient to obtain a medically necessary health service in accordance with 42 CFR §440.170.

These services are considered administrative expenditures.

Non-emergency medical transportation incorporates many types of services that do not require ~~emergency~~ ambulance transport~~, including non-emergency basic life support ambulance~~. The modes of non-emergency medical transportation depend upon the level of transportation needed by the recipient as follows:

1) Not for hire vehicles: this includes transportation provided by volunteer drivers, and family members or acquaintances of the recipient.
2) Unassisted transport: this includes transport provided by a taxi, public transit, or private medical transportation provider.
3) Assisted transport: this includes transport provided to recipients who require assistance by a nonemergency medical transportation provider.
4) Lift-equipped/ramp transport: this includes transport provided to a recipient who is dependent on a mobility device and requires a medical transportation provider with a vehicle containing a lift or ramp;
5) Protected transport: this includes transport provided to a recipient who has been screened and determined to require a provider with a protected vehicle that is not an ambulance or police car, which has safety locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver.
6) Stretcher transport: this includes transport for a recipient in a prone or supine position.

~~1. Basic life support (non-emergency) ambulance: scheduled transportation by a ground ambulance vehicle and medically necessary supplies and services, plus the provision of basic life support ambulance services;~~

~~2. Non-ambulance stretcher: transportation for a recipient who needs stretcher transport but does not require basic life support ambulance services;~~

METHODS OF PROVIDING TRANSPORTATION (continued)

~~3. Station-to-station assistance: transportation for a recipient who needs assistance from his or her place of pickup to his or her medically necessary destination;~~

~~4. Wheelchair assisted door-to-door services: transportation for a recipient who uses a wheelchair and requires driver assistance on a door-to-door basis, but does not require station-to-station assistance;~~

~~5. Door-to-door: transportation for a recipient who requires driver assistance from the recipient's front door to the outside door of the building where the health service is located;~~

~~6. Curb-to-curb: transportation for a recipient who enters the transport vehicle at the street curb of his or her residence or place of pickup and is dropped off at the street curb of the medical appointment.Station-to-station assistance is available if the recipient has a physical or mental impairment that would prohibit the recipient from safely accessing and using a bus, taxi, other commercial transportation, or private automobile. Such a recipient must not require ambulance transportation. Station-to-station assistance includes driver-assisted service that involves:~~

- ~~passenger pickup at and return to the recipient's residence or place of business;~~
- ~~assistance with admittance of the recipient to the medical facility; and~~
- ~~assistance in recipient securement or in securing of wheelchairs or stretchers in the vehicle.~~

Transportation may be furnished by a provider to whom a direct vendor payment can be made, a transportation coordinator who subcontracts with a transportation provider, or a local agency that has made transportation arrangements with local transportation providers ~~vendors~~. The transportation coordinator, enrolled providers, and the local agency shall ensure that non-emergency medical transportation services are available to a recipient to enable the recipient to obtain medically necessary health services ~~as required under Minnesota Rules, part 9505.0140~~.

METHODS OF PROVIDING TRANSPORTATION (continued)

Coverage Limitations

The following transportation services are not provided:

- Transportation services provided to obtain a service that is not a covered health service, except for non-emergency medical transportation of a ~~full-benefit~~ recipient dually eligible for Medicare and Medicaid, in order to obtain medications ~~drugs~~covered under the Medicare Part D benefit.

- Ambulance service in cases where another means of transportation would have sufficed.

- Transportation of a recipient to a non-covered service (e.g., grocery store, health club, place of worship).

- Charges for an additional attendant if a personal care attendant is accompanying a recipient as a covered service.

- Non-emergency medical transportation of a recipient between providers is a covered administrative expenditure except that transportation between two hospitals or two long term care facilities must be to obtain a medically necessary service that is not available at the hospital or long term care facility where the recipient was when the medical necessity was diagnosed.

~~- Coverage for non-emergency transportation of a deceased person is limited to the following circumstances:~~

  ~~- If a recipient is pronounced dead after non-emergency transportation is called but before it arrives, service to the point of pick-up is covered.~~

METHODS OF PROVIDING TRANSPORTATION (continued)

- ~~If non-emergency transportation is provided to a recipient who is pronounced dead on arrival, the medical transportation is covered.~~

- ~~If a recipient is pronounced dead before non-emergency transportation is called, medical transportation is not covered.~~

~~Coverage for station-to-station assistance is subject to the following limitations:~~

1) ~~Station-to-station service to reach a health service outside the recipient's local trade area is provided to a recipient who has been determined eligible for station-to-station assistance because of physical or mental impairment.~~
2) ~~Station-to-station services to a recipient who receives day services outside an intermediate care facility for persons with mental retardation is not covered under this section if the ICF/MR is responsible for the cost of transportation.~~

Transportation providers, except public transit and not-for-hire providers, must be certified by the Minnesota Department of Transportation.
~~To be eligible as a medical assistance administrative expenditure, the ambulance transportation must comply with the following~~:

1) ~~The provider must be licensed under Minnesota Statutes, 144E.10 and 144E.16.~~
2) ~~The medical necessity of the service must be documented.~~

LOCAL AGENCY PROCEDURE TO ENSURE ACCESS

Within 90 days after the first day of January, 1987, and every two years thereafter, the local agency shall submit to the Department a transportation plan that specifies the means the local agency will use to meet the transportation requirements.

The Department shall review the plan and advise the local agency whether it meets current state and federal requirements. The local agency shall inform a recipient of the county’s transportation plan.

METHODS OF PROVIDING TRANSPORTATION (continued)

A local agency may require prior approval of the payments of costs if exceptions are made for emergencies and retroactive eligibility.

LOCAL AGENCY PROCEDURE TO ENSURE ACCESS TO HEARINGS

Local agencies shall reimburse applicants and recipients for reasonable and necessary expenses for their attendance at a hearing held pursuant to Minnesota Rules, part 9505.0130, subpart 1.

METHODS OF PROVIDING TRANSPORTATION (continued)

The state assures that all minimum requirements outlined in section 1902(a)(87) of the Act are met. Those requirements include the following:

(A) Each provider and individual driver is not excluded from participation in any federal health care program (as defined in section 1128B(f) of the Act) and is not listed on the exclusion list of the Inspector General of the Department of Health and Human Services;

(B) Each such individual driver has a valid driver's license;

(C) Each such provider has in place a process to address any violation of a state drug law; and

(D) Each such provider has in place a process to disclose to the state Medicaid program the driving history, including any traffic violations, of each such individual driver employed by such provider, including any traffic violations.

STANDARDS FOR COVERAGE OF ORGAN AND TISSUE TRANSPLANTS

Medical Assistance coverage of organ and tissue transplants is limited to the following:

~~· Procedures covered by the Medicare Program.~~

· Procedures and diagnoses approved by the Department ~~and the Department's Advisory Committee on Organ and Tissue Transplants~~. These are published in the State Register.

· In accordance with §1138(a)(1)(B) of the Social Security Act, procedures performed in a facility that is a member of, and abides by the rules and requirements of, the Organ Procurement and Transplantation Network. The rules are found at 42 CFR Part 121.

· Organ transplants must be performed in a facility that meets United Network of Organ Sharing criteria for that organ transplant procedure or at Medicare-approved organ transplant centers.

· Stem cell (bone marrow) transplants must be performed in a facility that~~:~~

~~1) has been approved by the Department's Advisory Committee on Organ and Tissue Transplants; or~~

~~2~~) has Foundation for the Accreditation of Hematopoietic Cell Therapy accreditation.

· Heart and liver transplants must be performed in a facility approved by Medicare to perform that procedure. A pediatric hospital that has met CMS approval criteria for performing a heart or liver transplant on a child may also perform these transplants.

· Cornea and kidney transplants must be performed in a facility that participates as a provider of services in the Medicare Program, and meets Department of Human Services standards of safety and efficacy.

· Medical Assistance transplant coverage includes preoperative evaluation, recipient and donor surgery, follow-up care for the recipient and live donor, and harvesting and procurement of organs and tissues.

STANDARDS FOR COVERAGE OF ORGAN AND TISSUE TRANSPLANTS

Notwithstanding the above limitations, for children under the age of 21, this attachment complies with §1905(r)(5) of the Social Security Act.

These restrictions on the facilities and practitioners that may provide organ and tissue transplants help to assure that the designated providers render high quality care for which access is assured through local agency health care access plans.

~~Authorization is required for the following transplants: stem cell, heart-lung, liver, intestinal, liver-intestinal, lung (cadaveric and live donor) and pancreas. All other transplants performed in out-of-state facilities (which do not include facilities located in counties bordering Minnesota) also require prior authorization. The authorization process is defined in Minnesota Rules, parts 9505.5000 to 9505.5105, which is contained in Supplement 3 to Attachments 3.1-A and B. This rule was promulgated to assure the appropriate and consistent disposition of authorization requests, thereby assuring that similarly situated individuals are treated alike.~~

Emergency Medical Assistance under section 1903(v) of the Act does not include coverage for organ transplants or care and services related to organ transplantation.

State: MINNESOTA

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Minnesota enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization [MCOs], primary care case managers [PCCMs], and/or PCCM entities) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on state wideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date. All applicable assurances should be checked, even when the compliance date is in the future. **Please see Appendix A of this document for compliance dates for various sections of 42 CFR 438.**

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.2
42 CFR 438.6
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System.

The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. ☒ MCO
   a. ☒ Capitation
   b. ☒ The state assures that all applicable requirements of 42 CFR 438.6, regarding special contract provisions related to payment, will be met.

2. ☐ PCCM (individual practitioners)
   a. ☐ Case management fee
   b. ☐ Other (please explain below)

3. ☐ PCCM entity
   a. ☐ Case management fee
   b. ☐ Shared savings, incentive payments, and/or financial rewards(see 42 CFR 438.310(c)(2))
   c. ☐ Other (please explain below)

State: MINNESOTA

Citation	Condition or Requirement

If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as in 42 CFR 438.2), in addition to PCCM services:

- ☐ Provision of intensive telephonic case management
- ☐ Provision of face-to-face case management
- ☐ Operation of a nurse triage advice line
- ☐ Development of enrollee care plans.
- ☐ Execution of contracts with fee-for-service (FFS) providers in the FFS program
- ☐ Oversight responsibilities for the activities of FFS providers in the FFS program
- ☐ Provision of payments to FFS providers on behalf of the State.
- ☐ Provision of enrollee outreach and education activities.
- ☐ Operation of a customer service call center.
- ☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement.
- ☐ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.
- ☐ Coordination with behavioral health systems/providers.
- ☐ Coordination with long-term services and supports systems/providers.
- ☐ Other (please describe): _____

42 CFR 438.50(b)(4) C. Public Process.

Describe the public process including tribal consultation, if applicable, utilized for both the design of the managed care program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan managed care program has been implemented. *(Example: public meeting, advisory groups.)*
If the program will include long term services and supports (LTSS), please indicate how the views of stakeholders have been, and will continue to be, solicited and addressed during the design, implementation, and oversight of the program, including plans for a member advisory committee (42 CFR 438.70 and 438.110)

Methods used for design and ongoing public involvement include:

i. Legislative hearings regarding program changes where public testimony is taken and considered
ii. Notice and publication in the *State Register* with comment period
iii. Notice to American Indian Tribes with comment period
iv. Notice of, and discussion at, Medicaid Advisory Committee meetings
v. Public hearings by the Department to receive public comment
vi. Publication of changes to the Department's quality strategy on the

Department's website, along with notice of publication in the *State Register*

D. State Assurances and Compliance with the Statute and Regulations.
If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)

1. ☒ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

State: MINNESOTA

Citation	Condition or Requirement
42 CFR 438.50(c)(1)	
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. ☐ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts (including for PCCM entities) will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. ☒ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring beneficiaries to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C) 42 CFR 438.10(g)(2)(vii)	4. ☒ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A)	5. ☒ The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
1932(a)(1)(A) 42 CFR 438 1903(m)	6. ☒ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs, PCCMs, and PCCM entities will be met.
1932(a)(1)(A) 42 CFR 438.4 42 CFR 438.5 42 CFR 438.7 42 CFR 438.8 42 CFR 438.74 42 CFR 438.50(c)(6)	7. ☒ The state assures that all applicable requirements of 42 CFR 438.4, 438.5 438.7, 438.8, and 438.74 for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	8. ☐ The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.
45 CFR 75.326	9. ☒ The state assures that all applicable requirements of 45 CFR 75.326 for procurement of contracts will be met.
42 CFR 438.66	10. Assurances regarding state monitoring requirements:

State: MINNESOTA

Citation	Condition or Requirement

☒ The state assures that all applicable requirements of 42 CFR 438.66(a), (b), and (c), regarding a monitoring system and using data to improve the performance of its managed care program, will be met.
☒ The state assures that all applicable requirements of 42 CFR 438.66(d), regarding readiness assessment, will be met.
☒ The state assures that all applicable requirements of 42 CFR 438.66(e), regarding reporting to CMS about the managed care program, will be met.

1932(a)(1)(A)
1932(a)(2)

E. Populations and Geographic Area.

1. **Included Populations.** Please check which eligibility groups are included, if they are enrolled on a **Mandatory (M)** or **Voluntary (V)** basis (as defined in 42 CFR 438.54(b)) or **Excluded (E),** and the geographic scope of enrollment. Under the **Geographic Area** column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions. Also, if type of enrollment varies by geographic area (for example, mandatory in some areas and voluntary in other areas), please note specifics in the **Geographic Area** column. Under the **Notes** column, please note any additional relevant details about the population or enrollment.

A. Mandatory Eligibility Groups (Eligibility Groups to which a state must provide Medicaid coverage)

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Parents and Other Caretaker Relatives	§435.110	X			statewide	
2. Pregnant Women	§435.116	X			statewide	
3. Children Under Age 19 (Inclusive of Deemed Newborns under §435.117)	§435.118	X			statewide	
4. Former Foster Care Youth (up to age 26)	§435.150	X			statewide	
5. Adult Group (Non-pregnant individuals age 19-64 not eligible for Medicare with income no more than 133% FPL)	§435.119	X			statewide	
6. Transitional Medical Assistance (Includes adults and children, if not eligible under §435.116, §435.118, or §435.119)	1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of SSA	X			statewide	
7. Extended Medicaid Due to Spousal Support Collections	§435.115	X			statewide	

State: MINNESOTA

Citation | Condition or Requirement

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
8. Individuals Receiving SSI age 19 and over only (See E.2. below regarding age <19)	§435.120			X	statewide	
9. Aged and Disabled Individuals in 209(b) States	§435.121			X	statewide	
10. Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increase since April, 1977	§435.135			X	statewide	
11. Disabled Widows and Widowers Ineligible for SSI due to an increase of OASDI	§435.137			X	statewide	
12. Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	§435.138			X	statewide	
13. Working Disabled under 1619(b)	1619(b), 1902(a)(10)(A)(i)(II), and 1905(q) of SSA			X	statewide	
14. Disabled Adult Children	1634(c) of SSA			X	statewide	

B. Optional Eligibility Groups

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Optional Parents and Other Caretaker Relatives	§435.220					N/A
2. Optional Targeted Low-Income Children	§435.229	X			Statewide	
3. Independent Foster Care Adolescents Under Age 21	§435.226					N/A
4. Individuals Under Age 65 with Income Over 133%	§435.218					N/A
5. Optional Reasonable Classifications of Children Under Age 21	§435.222			X	Statewide	
6. Individuals Electing COBRA Continuation Coverage	1902(a)(10)(F) of SSA					N/A
7. Individuals eligible or coverage under the authority of Minnesota Prepaid Medical Assistance Project Plus (PMAP+) section 1115 waiver (11-W-00039/5)	1115(a) of SSA	X		X	Statewide	Presumptive eligibility months for Pregnant Women are excluded from managed care.

State: MINNESOTA

Citation | Condition or Requirement

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
7. Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash	§435.210 and §435.230			X	Statewide	
8. Individuals eligible for Cash except for Institutionalized Status	§435.211			X	Statewide	
9. Individuals Receiving Home and Community-Based Waiver Services Under Institutional Rules	§435.217			X	Statewide	
10. Optional State Supplement Recipients - 1634 and SSI Criteria States – with 1616 Agreements	§435.232					N/A
11. Optional State Supplemental Recipients- 209(b) States and SSI criteria States without 1616	§435.234			X	Statewide	
12. Institutionalized Individuals Eligible under a Special Income Level	§435.236	X			Statewide	
13. Individuals Participating in a PACE Program under Institutional Rules	1934 of the SSA					N/A
14. Individuals Receiving Hospice Care	1902(a)(10)(A)(ii)(VII) and 1905(o) of the SSA					N/A
15. Poverty Level Aged or Disabled	1902(a)(10)(A)(ii)(X) and 1902(m)(1) of the SSA					N/A
16. Work Incentive Group	1902(a)(10)(A)(ii)(XIII) of the SSA			X	Statewide	
17. Ticket to Work Basic Group	1902(a)(10)(A)(ii)(XV) of the SSA					N/A
18. Ticket to Work Medically Improved Group	1902(a)(10)(A)(ii)(XVI) of the SSA					N/A
19. Family Opportunity Act Children with Disabilities	1902(a)(10)(A)(ii)(XIX) of the SSA					N/A
20. Individuals Eligible for State Plan Home and Community-Based Services	§435.219					N/A

State: MINNESOTA

Citation | Condition or Requirement

3. Partial Benefits

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
21. Family Planning Services	§435.214			X	Statewide	
22. Individuals with Tuberculosis	§435.215					N/A
23. Individuals Needing Treatment for Breast or Cervical Cancer (under age 65)	§435.213			X	Statewide	

C. Medically Needy

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Medically Needy Pregnant Women	§435.301(b)(1)(i) and (iv)			X	Statewide	
2. Medically Needy Children under Age 18	§435.301(b)(1)(ii)			X	Statewide	
3. Medically Needy Children Age 18 through 20	§435.308			X	Statewide	
4. Medically Needy Parents and Other Caretaker Relatives	§435.310			X	Statewide	
5. Medically Needy Aged	§435.320					N/A
6. Medically Needy Blind	§435.322					N/A
7. Medically Needy Disabled	§435.324					N/A
8. Medically Needy Aged, Blind and Disabled in 209(b) States	§435.330			X	Statewide	

2. **Voluntary Only or Excluded Populations.** Under this managed care authority, some populations cannot be subject to mandatory enrollment in an MCO, PCCM, or PCCM entity (per 42 CFR 438.50(d)). Some such populations are Eligibility Groups separate from those listed above in E.1., while others (such as American Indians/Alaskan Natives) can be part of multiple Eligibility Groups identified in E.1. above.

Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

State: MINNESOTA

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
Medicare Savings Program – Qualified Medicare Beneficiaries, Qualified Disabled Working Individuals, Specified Low Income Medicare Beneficiaries, and/or Qualifying Individuals	1902(a)(10)(E), 1905(p), 1905(s) of the SSA		X	statewide	

State: MINNESOTA

Citation Condition or Requirement

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
"Dual Eligibles" not described under Medicare Savings Program - Medicaid beneficiaries enrolled in an eligibility group other than one of the Medicare Savings Program groups who are also eligible for Medicare				statewide	Enrollment follows the policy of the individual's age group, or specific eligibility group.
American Indian/Alaskan Native— Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes	§438.14	X	X	statewide	American Indian people who live on a reservation may enroll voluntarily.
Children Receiving SSI who are Under Age 19 - Children under 19 years of age who are eligible for SSI under title XVI	§435.120		X	statewide	
Qualified Disabled Children Under Age 19 - Certain children under 19 living at home, who are disabled and would be eligible if they were living in a medical institution.	§435.225 1902(e)(3) of the SSA		X	statewide	TEFRA children
Title IV-E Children - Children receiving foster care, adoption assistance, or kinship guardianship assistance under title IV-E *	§435.145	X		statewide	
Non-Title IV-E Adoption Assistance Under Age 21*	§435.227	X		Statewide	
Children with Special Health Care Needs - Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the State in terms of either program participation or special health care needs.			X	N/A	

* = Note – Individuals in these two Eligibility Groups who are age 19 and 20 can have mandatory enrollment in managed care, while those under

age 19 cannot have mandatory enrollment. Use the Notes column to indicate if you plan to mandatorily enroll 19 and 20 year olds in these Eligibility Groups.

3. **(Optional) Other Exceptions.** The following populations (which can be part of various Eligibility Groups) can be subject to mandatory enrollment in managed care, but states may elect to make exceptions for these or other individuals. Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

State: MINNESOTA

Citation Condition or Requirement

Population	V	E	Notes
Other Insurance--Medicaid beneficiaries who have other health insurance	X	X	Individuals with private health insurance coverage through an HMO licensed under Minnesota Statutes, Chapter 62D are excluded. These persons may enroll on a voluntary basis if the private HMO is the same as the MCO consumer will select under PMAP. Individuals with private health insurance that has been determined to be cost-effective are excluded from enrollment.
Reside in Nursing Facility or ICF/IID-- Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).	X		
Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program		X	
Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program			N/A
Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).	X		
Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.		X	
Other (Please define): **Residents of State Institutions.** This includes regional treatment centers, "institutions for mental diseases" and other state-operated facilities, if the individual resides in the state institution at the time of enrollment. Residents of state institutions who were already enrolled in managed care at the time of placement remain enrolled if the placement has been approved by the MCO.		X	
Noncitizens eligible for coverage of emergency medical conditions under § 1903(b) of the SSA.		X	

State: MINNESOTA

Population	V	E	Notes
Individuals with Terminal Illness (defined as a prognosis of six months or less to live) who, at the time of enrollment, have an established relationship with a primary care physician who is not part of a PMAP network are excluded. Individuals with a communicable disease and a prognosis of terminal are also excluded if the person's physician is not a participating provider and the physician certifies that disruption of the physician/patient relationship is likely to result in noncompliance with medication or other health services. This exclusion occurs even if the prognosis is more than six months.		X	
Persons who are eligible with a medical spenddown.	X		
Children with Severe Emotional Disturbance (SED).	X	X	Children with severe emotional disturbance that meets the definition of need for mental health targeted case management services are excluded but may enroll on a voluntary basis.
Adults with Serious and Persistent Mental Illness (SPMI).	X	X	Adults with SPMI that meets the definition of need for mental health targeted case management services are excluded, but may voluntarily enroll.
Women eligible for MA through the Breast and Cervical Cancer Control Program.		X	
Individuals Temporarily Out of the State		X	This applies to people who are absent from the state for more than 30 consecutive days.
Individuals who are participating in the Chemical Health Care Services Pilot Project authorized under Minnesota Statutes, section 254B.13.		X	
Individuals who are required to enroll are excluded for the time period between application and enrollment in the MCO.		X	
Individuals required to enroll or who enroll voluntarily are excluded for the months of retroactive coverage.		X	
Children under age 19 receiving SSI who choose MAGI-based categorically needy eligibility.			N/A

State: MINNESOTA

Individuals under age 65 who are receiving Medicare or who are blind or disabled, who are in a eligibility group for which enrollment is mandated.			N/A

1932(a)(4)
42 CFR 438.54

F. Enrollment Process.

Based on whether mandatory and/or voluntary enrollment are applicable to your program (see E. Populations and Geographic Area and definitions in 42 CFR 438.54(b)), please complete the below:

1. For **voluntary** enrollment: (see 42 CFR 438.54(c))
   a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(c)(3).

   Eligible consumers are mailed an enrollment packet in advance of the annual health plan selection period. Materials describing the available managed care plans and the process to select one, or opt not to select and be enrolled in a default plan, or not to enroll in managed care and thus enroll in the FFS program, are provided.

   State with voluntary enrollment must have an enrollment choice period or passive enrollment. Please indicate which will apply to the managed care program:
   Enrollment choice period of 30 days.

   b. X☐ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(c)(1)(i) and 42 CFR 438.54(c)(2)(i), during which individuals who are subject to voluntary enrollment may make an active choice to enroll in the managed care program, or will otherwise continue to receive covered services through the fee-for-service delivery system.
      i. Please indicate the length of the enrollment choice period:
      Consumers have 30 days to choose an MCO.

State: MINNESOTA

Citation	Condition or Requirement

c. ☐ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(c)(1)(ii) and 438.54(c)(2)(ii), for individuals who are subject to voluntary enrollment.

i. If so, please describe the algorithm used for passive enrollment and how the algorithm and the state's provision of information meets all of the requirements of 42 CFR 438.54(c)(4),(5),(6),(7), and (8).

ii. Please indicate how long the enrollee will have to disenroll from the plan and return to the fee-for-service delivery system:

_____

2. For **mandatory** enrollment: (see 42 CFR 438.54(d))

a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(d)(3).

3.

a. ☒ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(d)(2)(i), during which individuals who are subject to mandatory enrollment may make an active choice to select a managed care plan, or will otherwise be enrolled in a plan selected by the State's default enrollment process.

i. Please indicate the length of the enrollment choice period:

Consumers have 30 days to choose an MCO. Those who do not make a choice are enrolled via a default enrollment process.

b. ☒ If applicable, please check here to indicate that the state uses a **default** enrollment process, as described in 42 CFR 438.54(d)(5), for individuals who are subject to mandatory enrollment.

i. If so, please describe the algorithm used for default enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (5), (7), and (8).

a. The Department determines whether the recipient or an associated household member has an existing MCO/recipient relationship. If there is a relationship, the recipient is enrolled in that same MCO.

b. The system determines a default MCO by searching to determine if any household member is enrolled in managed care. If that MCO is available in the recipient's county of residence, that MCO becomes the default.

c. If no household member is enrolled in an available MCO, then the state will direct enrollment into the default MCO for each county as determined by the results of the most

d.

recent managed care procurement. Defaults are assigned by the MMIS system and may be a single MCO or several MCOs assigned on a rotating basis. MCOs must have capacity to contract with DHS and be determined a default plan, however if there were a cap on enrollment current enrollees would receive priority enrollment. All default MCOs must not be subject to intermediate sanction. Each default MCO must have a broad network of providers that are accustomed to serving Minnesota's MA population.

c. ☐ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(d)(2), for individuals who are subject to mandatory enrollment.

i. If so, please describe the algorithm used for passive enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (6), (7), and (8).

1932(a)(4)
42 CFR 438.54

3. State assurances on the enrollment process.

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

42 CFR 438.52

a. ☒ The state assures that, per the choice requirements in 42 CFR 438.52:

State: MINNESOTA

Citation	Condition or Requirement

i. Medicaid beneficiaries with mandatory enrollment in an MCO will have a choice of at least two MCOs unless the area is considered rural as defined in 42 CFR 438.52(b)(3);
ii. Medicaid beneficiaries with mandatory enrollment in a primary care case management system will have a choice of at least two primary care case managers employed by or contracted with the State;
iii. Medicaid beneficiaries with mandatory enrollment in a PCCM entity may be limited to a single PCCM entity and will have a choice of at least two PCCMs employed by or contracted with the PCCM entity.

42 CFR 438.52

b. ☒The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties: Morrison, Pipestone, Pope, Renville, Steele, Stevens, Todd, Traverse, Wadena, Waseca.

42 CFR 438.56(g)

☐ This provision is not applicable to this 1932 State Plan Amendment.

c. ☒ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

☐ This provision is not applicable to this 1932 State Plan Amendment.

42 CFR 438.71

d. ☒ The state assures that all applicable requirements of 42 CFR 438.71 regarding developing and implementing a beneficiary support system that provides support to beneficiaries both prior to and after MCO, PCCM, or PCCM entity enrollment will be met.

1932(a)(4)
42 CFR 438.56

G. Disenrollment.

1. The state will ☒/ will not☐ limit disenrollment for managed care.

2. The disenrollment limitation will apply for 12 months (up to 12 months).

3. ☒The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56.

4. Describe the state's process for notifying the Medicaid beneficiaries of their right to disenroll without cause during the 90 days following the date of their initial enrollment into the MCO, PCCM, or PCCM entity. *(Examples: state generated correspondence, enrollment packets, etc.)*

All enrollee rights information is included in enrollment packets.

5. Describe any additional circumstances of "cause" for disenrollment (if any).

-When travel time to an enrollee's primary care provider is over 30 minutes from the enrollee's residence;
-When an enrollee's choice was incorrectly designated due to Department error.

State: MINNESOTA

Citation	Condition or Requirement

H. Information Requirements for Beneficiaries.

1932(a)(5)(c)
42 CFR 438.50
42 CFR 438.10

☒ The state assures that its state plan program is in compliance with 42 CFR 438.10 for information requirements specific to MCOs, PCCMs, and PCCM entity programs operated under section 1932(a)(1)(A)(i) state plan amendments.

1932(a)(5)(D)(b)
1903(m)
1905(t)(3)

I. List all benefits for which the MCO is responsible.

Complete the chart below to indicate every State Plan-Approved services that will be delivered by the MCO, and where each of those services is described in the state's Medicaid State Plan. For "other practitioner services", list each provider type separately. For rehabilitative services, habilitative services, EPSDT services and 1915(i), (j) and (k) services list each program separately by its own list of services. Add additional rows as necessary.

In the first column of the chart below, enter the name of each State Plan-Approved service delivered by the MCO. In the second – fourth column of the chart, enter a State Plan citation providing the Attachment number, Page number, and Item number, respectively.

1932(a)(5)(D)(b)(4)
42 CFR 438.228

J. ☒ The state assures that each MCO has established an internal grievance and appeal system for enrollees

State: MINNESOTA

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #
Inpatient hospital services	3.1-A		1.
Outpatient hospital services			2.a.
Rural health clinic services			2.b.
Other laboratory services			3.
Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age			4.b.
Diagnostic assessments		16	
• Children's Therapeutic Services and Supports		16a-2	
• Crisis response services		16h	
• Services provided to recipients with severe emotional disturbance residing in a children's residential treatment facility.		16oo	
• Youth assertive community treatment		16rr	
• Family psychoeducation services		16uu	
• In-reach care coordination		16vv	
• Mental health clinical care consultation		16vv	
• Certified family peer specialists		16ww	
• Early Intensive Developmental and Behavioral Intervention (EIDBI)		16xx-1	
Family planning services and supplies		17	4.c.
Physicians' services			5.a.
• Psychiatric services		18	
• Sterilization procedures		18	
• Psychiatric consultations		18	
• Optometry Services		18	

State: MINNESOTA

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #
Health care home services	3.1-A	18b	
In-reach care coordination services		18d	
Community paramedic services		18e	
Community Emergency Medical Technician Services		18e	
Medical and surgical services furnished by a dentist		19	5.b.
Podiatrists' services		21	6.a.
Optometrists' services		22	6.b.
Chiropractors' services		23	6.c.
Other practitioners' services		24	6.d.
Mental health services		24	
• In-reach care coordination		24a	
• Public health nursing services		25	
• Acupuncture services		26	
• Certified nurse anesthetist		27	
• Nurse practitioner services		28	
• Case management for people receiving clozapine		29	
• Clinical nurse specialist services		31	
• Medication therapy management services		31.1	
Home Health services		32	7.
Intermittent or part-time nursing services provided by a home health agency or a registered nurse when no home health agency exists in the area.		33	7.a.
Home health aide services			7.b.

State: MINNESOTA

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #
Medical supplies, equipment, and appliances suitable for use in the home.	3.1-A	35	7.c.
• Augmentive and alternative communication devices		35	
• Asthma reduction services		35	
Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency		36	7.d.
Private duty nursing services		37	8.
Clinic services		38	9.
• Ambulatory surgical center services		38	
Dental services		39	10.
Physical therapy and related services			11.
Physical therapy		41	11.a.
Occupational therapy		41	11.b.
Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).		43	11.c.
• Hearing aid services		43e	
Drugs		45	12.a.
Dentures		46	12.b.
Prosthetic devices		47	12.c.
Eyeglasses		48	12.d.
Diagnostic services		50	13.a.
Screening services		51	13.b.
Preventive services		52	13.c.

State: MINNESOTA

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #
Rehabilitative services	3.1-A	53	13.d.
• Community mental health services		53	
• Community health worker services		53b	
• Adult rehabilitative mental health services		53b	
• Mental health crisis response		53g.1	
• Dialectical behavioral therapy services		53j	
• Assertive community treatment		53k	
• Intensive residential treatment services		53m	
• Substance use disorder treatment services		53q	
• Certified Community Behavioral Health Center services		53u	
Inpatient psychiatric facility services for individuals under 22 years of age.		60	16.
Nurse-midwife services.		61	17.
Hospice care (in accordance with section 1905(o) of the Act)		62	18
Case management services			19.
Extended services for pregnant women		65	20.a.
Prenatal risk assessment		65	
Antepartum management and care coordination		65a	
Prenatal health and nutrition education		65b	
Postpartum home visiting		65g	
Doula services		65i	
Services for any other medical conditions that may complicate pregnancy		66	20.b.
Certified pediatric or family nurse practitioners' services		69	23.
Transportation		71	24.a.
Care and services provided in religious nonmedical health care institutions		73	24.c.
Emergency hospital services		75	24.e.
Personal care services		77	26.
Freestanding birth center services		78a	28.
Integrated care models		79b	31
Cost of routine care in clinical trials		78b.3	30
Medication Assisted Treatment	3.1-A Supplement 7	1	31

State: MINNESOTA

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #
~~State Plan~~	~~3.1 i a~~	~~all~~	
~~Community First Supports; included only in MCOs for elderly (enrollment in MSC+ plans is mandated under a 1915(b) waiver); and included in Minnesota Senior Health Options plans (voluntary enrollment).~~	~~3.1 k~~	~~all~~	

State: MINNESOTA

Citation	Condition or Requirement
1932(a)(5)(D)(b)(4) 42 CFR 438.228	J. ☒ The state assures that each MCO has established an internal grievance and appeal system for enrollees.
1932(a)(5)(D)(b)(5) 42 CFR 438.62 42 CFR 438.68 42 CFR 438.206 42 CFR 438.207 42 CFR 438.208	K. Services, including capacity, network adequacy, coordination, and continuity. ☒ The state assures that all applicable requirements of 42 CFR 438.62, regarding continued service to enrollees, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.68, regarding network adequacy standards, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.206, regarding availability of services, will be met. ☒The state assures that all applicable requirements of 42 CFR 438.207, regarding assurances of adequate capacity and services, will be met. ☒The state assures that all applicable requirements of 42 CFR 438.208, regarding coordination and continuity of care, will be met.
1932(c)(1)(A) 42 CFR 438.330 42 CFR 438.340	L. ☒ The state assures that all applicable requirements of 42 CFR 438.330 and 438.340, regarding a quality assessment and performance improvement program and State quality strategy, will be met.
1932(c)(2)(A) 42 CFR 438.350 42 CFR 438.354 42 CFR 438.364	M. ☒ The state assures that all applicable requirements of 42 CFR 438.350, 438.354, and 438.364 regarding an annual external independent review conducted by a qualified independent entity, will be met.
1932 (a)(1)(A)(ii)	N. Selective Contracting Under a 1932 State Plan Option. To respond to items #1 and #2, place a check mark. The third item requires a brief narrative. 1. The state will ☒/will not ☐ intentionally limit the number of entities it contracts under a 1932 state plan option.

State: MINNESOTA

Citation	Condition or Requirement

2. ☒ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

The Department may limit the number of entities it contracts with in a given area, depending on a number of factors, including MCO capacity, networks, and administrative cost and effort.

4. ☐ The selective contracting provision in not applicable to this state plan.

State: MINNESOTA

Citation	Condition or Requirement

Appendix A: Compliance Dates (from Supplementary Information in 81 FR 27497, published 5/6/2016)

States must comply with all provisions in effect as of the issuance of this preprint. Additionally, the following compliance dates apply:

Compliance Dates	Sections
For rating periods for Medicaid managed care contracts beginning before July 1, 2017, States will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2017.**	§§ 438.3(h), 438.3(m), 438.3(q) through (u), 438.4(b)(7), 438.4(b)(8), 438.5(b) through (f), 438.6(b)(3), 438.6(c) and (d), 438.7(b), 438.7(c)(1) and (2), 438.8, 438.9, 438.10, 438.14, 438.56(d)(2)(iv), 438.66(a) through (d), 438.70, 438.74, 438.110, 438.208, 438.210, 438.230, 438.242, 438.330, 438.332, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424, 438.602(a), 438.602(c) through (h), 438.604, 438.606, 438.608(a), and 438.608(c) and (d)
For rating periods for Medicaid managed care contracts beginning before July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2018.**	§§ 438.4(b)(3), 438.4(b)(4), 438.7(c)(3), 438.62, 438.68, 438.71, 438.206, 438.207, 438.602(b), 438.608(b), and 438.818
States must be in compliance with the requirements at § 438.4(b)(9) no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2019.	§ 438.4(b)(9)
States must be in compliance with the requirements at § 438.66(e) no later than the rating period for Medicaid managed care contracts starting on or after the date of the publication of CMS guidance.	§ 438.66(e)
States must be in compliance with § 438.334 no later than 3 years from the date of a final notice published in the Federal Register.	§ 438.334
Until July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42	§§ 438.340, 438.350, 438.354, 438.356, 438.358, 438.360, 438.362, and 438.364

State: MINNESOTA

Citation | Condition or Requirement

Compliance Dates	Sections
CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.	
States must begin conducting the EQR-related activity described in § 438.358(b)(1)(iv) (relating to the mandatory EQR-related activity of validation of network adequacy) **no later than one year from the issuance of the associated EQR protocol.**	§ 438.358(b)(1)(iv)
States may begin conducting the EQR-related activity described in § 438.358(c)(6) (relating to the optional EQR-related activity of plan rating) **no earlier than the issuance of the associated EQR protocol.**	§ 438.358(c)(6)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

CMS-10120 (exp. TBD – currently 4/30/17)

Health Homes Intro

Package ID	MN2019MS0004O	SPA ID	MN-19-0015
Submission Type	Official	Initial Submission Date	9/27/2019
Approval Date	12/10/2019	Effective Date	10/1/2019
Superseded SPA ID	MN2016MH0002O		

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

Behavioral Health Homes

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

Behavioral health home services are available to adults with serious mental illness and children and youth experiencing an emotional disturbance.

This amendment supports improved delivery of BHH services by clearly identifying the expectations of all certified BHH services providers, improving access to services, and improving provider requirements. This amendment contains changes made by the 2019 Minnesota Legislature to strengthen the framework of BHH services, to support the capacity of providers delivering BHH services and to increase access to services and is effective upon federal approval.

In addition to the first general assurance below that eligible individuals are assured a free choice of Health Homers providers, the state assures that individuals will be given free choice of providers of all other medical assistance services, and for managed care enrollees, a choice of all other medical providers within the plan's network.

General Assurances

- The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- The state provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Geographic Limitations

Package ID	MN2019MS0004O	SPA ID	MN-19-0015
Submission Type	Official	Initial Submission Date	9/27/2019
Approval Date	12/10/2019	Effective Date	10/1/2019
Superseded SPA ID	MN2016MH0002O		

User-Entered

- (●) Health Homes services will be available statewide
- ( ) Health Homes services will be limited to the following geographic areas
- ( ) Health Homes services will be provided in a geographic phased-in approach

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | MN2019MS0004O | MN-19-0015 | Behavioral Health Homes

Package ID	MN2019MS0004O	SPA ID	MN-19-0015
Submission Type	Official	Initial Submission Date	9/27/2019
Approval Date	12/10/2019	Effective Date	10/1/2019
Superseded SPA ID	MN2016MH0002O		

Categories of Individuals and Populations Provided Health Home Services

The state will make Health Home services available to the following categories of Medicaid participants

- [ ] Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- [ ] Medically Needy Eligibility Groups

Mandatory Medically Needy

Medically Needy Pregnant Women

- [ ] Medically Needy Children under Age 18

Optional Medically Needy (select the groups included in the population)

Families and Adults

- [ ] Medically Needy Children Age 18 through 20
- [ ] Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

- [ ] Medically Needy Aged, Blind or Disabled
- [ ] Medically Needy Blind or Disabled Individuals Eligible in 1973

Health Homes Population and Enrollment Criteria

Package ID	MN2019MS0004O	SPA ID	MN-19-0015
Submission Type	Official	Initial Submission Date	9/27/2019
Approval Date	12/10/2019	Effective Date	10/1/2019
Superseded SPA ID	MN2016MH0002O		

Population Criteria

The state elects to offer Health Homes services to individuals with:

- [ ] Two or more chronic conditions
- [ ] One chronic condition and the risk of developing another
- [x] One serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition:

Behavioral health home services will be made available to adults with serious mental illness, and children and youth experiencing emotional disturbance. Serious mental illness and emotional disturbance are defined as an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation.

Recipients must have a diagnosis by a qualified mental health professional (including a physician) within the past 12 months that meets the criteria for serious mental illness (SMI) or emotional disturbance (ED). A diagnostic assessment is required within the first six months of BHH services to ensure a person is connected to Medicaid covered behavioral health treatment supports and services.

Health Homes Population and Enrollment Criteria

Package ID	MN2019MS0004O	SPA ID	MN-19-0015
Submission Type	Official	Initial Submission Date	9/27/2019
Approval Date	12/10/2019	Effective Date	10/1/2019
Superseded SPA ID	MN2016MH0002O		

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home:

- (•) Opt-In to Health Homes provider
- ( ) Referral and assignment to Health Homes provider with opt-out
- ( ) Other (describe)

Describe the process used:

In order to receive BHH services, an individual must have a diagnosis by a qualified health professional (including a physician) within the past 12 months that meets the criteria for serious mental illness (SMI) or emotional disturbance (ED).

The Department will provide certified behavioral health homes (BHH) with a list of individuals identified by the claims payment system who meet the criteria to receive BHH services and are currently served by the BHH provider.

The state will also support the identification of individuals who are not currently receiving BHH or other case management services. Certified behavioral health homes will engage eligible individuals, or individuals may self-refer for BHH services. Participation in behavioral health homes is voluntary.

Individuals who meet the criteria will receive information regarding their choice to receive BHH services.

Individuals will then have the ability to opt in to receive BHH services. The opt-in process will include a consent form that will include the individual rights and responsibilities as a recipient of these services.

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | MN2023MS0001O | MN-23-0027 | Behavioral Health Homes

Package Header

Package ID MN2023MS0001O

SPA ID MN-23-0027

Submission Type Official

Initial Submission Date 9/18/2023

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Superseded SPA ID MN-22-0036

System-Derived

Types of Health Homes Providers

☐ Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

☐ Physicians

☐ Clinical Practices or Clinical Group Practices

Describe the Provider Qualifications and Standards

•Be enrolled as a Medical Assistance provider, and provide a medical assistance covered primary care or behavioral health service.
•Successfully complete and maintain state certification as a behavioral health home provider.

☐ Rural Health Clinics

Describe the Provider Qualifications and Standards

•Be enrolled as a Medical Assistance provider, and provide a medical assistance covered primary care or behavioral health service.
•Successfully complete and maintain state certification as a behavioral health home provider.

☐ Community Health Centers

Describe the Provider Qualifications and Standards

•Be enrolled as a Medical Assistance provider, and provide a medical assistance covered primary care or behavioral health service.
•Successfully complete and maintain state certification as a behavioral health home provider.

☐ Community Mental Health Centers

Describe the Provider Qualifications and Standards

•Be enrolled as a Medical Assistance provider, and provide a medical assistance covered primary care or behavioral health service.
•Successfully complete and maintain state certification as a behavioral health home provider.

☐ Home Health Agencies

☐ Case Management Agencies

☐ Community/Behavioral Health Agencies

Describe the Provider Qualifications and Standards

•Be enrolled as a Medical Assistance provider, and provide a medical assistance covered primary care or behavioral health service.
•Successfully complete and maintain state certification as a behavioral health home provider.

☐ Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards

•Be enrolled as a Medical Assistance provider, and provide a medical assistance covered primary care or behavioral health service.
•Successfully complete and maintain state certification as a behavioral health home provider.

☐ Other (Specify)

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | MN2023MS0001O | MN-23-0027 | Behavioral Health Homes

Package Header

Package ID	MN2023MS0001O	SPA ID	MN-23-0027
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	System-Derived		

☐ Teams of Health Care Professionals

☐ Health Teams

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | MN2023MS0001O | MN-23-0027 | Behavioral Health Homes

Package Header

Package ID	MN2023MS0001O	SPA ID	MN-23-0027
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	System-Derived		

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

The state will use the designated provider model for behavioral health homes. Behavioral health homes must be enrolled as a Medicaid provider prior to serving as a behavioral health home and must provide services through a team-based model of care. All behavioral health homes must include the following team members:

Team Member: Team Leader
Required Qualifications:
• Clinic manager
• Medical Director, or
• Other management-level professional

Team Member: Integration Specialist
Required Qualifications:
• Licensed nurse, including an Advanced Practice Registered Nurse, registered nurse, and licensed practical nurse; or
• Mental health professional as defined in the state plan in item 6.d.A. of Attachments 3.1-A/B

Team Member: Behavioral Health Home Systems Navigator
Required Qualifications:
• Mental health practitioner as defined in Attachments 3.1-A/B, item 4.b; or
• Community health worker.

Team Member: Qualified Health Home Specialist
Required Qualifications:
• Case management associate as defined in Attachments 3.1-A/B, supplement 1;
• Mental health rehabilitation worker as defined in Attachments 3.1-A/B, item 13.d.;
• Community health worker;
• Mental health certified peer support specialist as defined in Attachments 3.1-A/B, item 13.d;
• Mental health certified family peer support specialist as defined in Attachments 3.1-A/B, item 4.b;
• Community paramedic as defined in Attachments 3.1-A/B, item 5.a;
• Qualified substance use disorder peer recovery specialist.

Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

Minnesota convened a group of providers that were interested in becoming certified BHHs. The group is known as the first implementers group. The purpose of the first implementers group is to receive support from DHS in order to prepare for BHH certification, and to share best practices. Thirty-nine agencies across the state, including the Indian Health Board, have indicated interest in participating. An initial needs assessment was conducted and will inform the development of curriculum focused on behavioral health home certification and on topics related to integration of mental and physical health.

The Department will continue to encourage ongoing, collaborative learning by offering educational opportunities such as webinars and regional meetings.

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

Every BHH services provider must be an enrolled MA provider and provide a medical assistance covered primary care or behavioral health service, and must obtain and maintain certification by the Department as a certified BHH services provider. This certification requires demonstration of the ability and capacity to perform the following:

•Maintain the required BHH services team structure as described above and provide comprehensive care management, care coordination and health promotion, comprehensive transitional care, individual and family support services, and referrals to community and social support services.

•Utilize a team-based model of care including regular coordination and communication between members of the BHH services team.

•Conduct comprehensive screenings that address behavioral, medical, and social service and community support needs and refer an individual to resources appropriate to the individual's screening results. Screenings must be consistent with professional standards of care.

•Create and maintain an individualized health action plan for each recipient that accurately reflects the individual's preferences, goals, resources, and optimal outcomes for the individual and the
- individual's identified supports, and encompasses behavioral health, physical health, social services, and community supports. In addition, providers must:
- provide a central point of contact to ensure successful navigation of the array of services that may affect the person's health and well-being;
- have capacity to assess the person's readiness for change and capacity to integrate new supports into one's life;
- offer of facilitate wellness and prevention education specific to the prevention and management of common chronic conditions;
- assist the person with setting up and preparing for appointments (medical, behavioral health, social service, or community support services), including accompanying the person, and following up with
the person after appointments;
- offer or facilitate health coaching related to chronic disease management and coaching on navigating complex systems of care, to the person, the person's family and identified supports;
- connect the person, family and identified supports to appropriate support services that help the person overcome access or service barriers, increase self-sufficiency skills, and improve overall health;
- provide effective referrals and timely access to services;
- establish a continuous quality improvement process for providing behavioral health home services;
- create a plan with the person and the person's identified supports for the support of the person after discharge from a hospital, residential treatment program, or other setting. The plan must have
protocols for maintaining contact between the assigned BHH provider team member, the person and the person's identified supports during and after discharge; linking the person to new resources;
reestablishing the person's existing services and community supports; and following up with other entities to transfer or obtain the person's service records as necessary for continued care.

•Use health information technology to link services, identify and manage gaps in care, and facilitate communication among team members and other providers.

•Use an electronic health record and patient registry to collect data at the individual and practice levels that allows them to identify, track, and segment the population to improve outcomes over time.

•Establish processes in order to identify and share individual level information in a timely manner with professionals and providers that are involved in the individual's care.

•Demonstrate efforts to engage area hospitals, primary care practices and behavioral health providers to collaborate with the behavioral health home on care coordination.

•When feasible, establish policies and written agreements with primary care providers (or mental health providers when behavioral health home services are delivered in a primary care setting) to ensure communication and integration of care.

•Track individuals' medications and lab results, to support symptom management. BHH services providers will use this data to discuss treatment options with a recipient's primary care or behavioral health professional.

•Demonstrate commitment by leadership to pursue integration and support practice transformation.

•Establish a continuous quality improvement plan, and collect and report data that will inform state and federal evaluations.

BHH teams will be integrated with both primary care and behavioral health professionals:

• In a behavioral health setting, the required integrated team must include a nurse care manager.

• In a primary care setting, the team must include a licensed mental health professional.

Behavioral health home providers must also:

•Directly provide, or subcontract for, the provision of care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services and have policies and procedures to track referrals to ensure that the referral met the individual's needs.

•Maintain documentation of all team member qualifications in their personnel files.

•Participate in federal and state-required evaluation activities including documentation of behavioral health home services.

•Comply with all of the terms and conditions of certification.

•A BHH services provider planning to terminate the delivery of behavioral health home services must give 60-day notice to the Department, all of its people receiving BHH services, and applicable managed care plans. Providers must assist the recipient with finding a new behavioral health home provider.

•Provide recipients with BHH services program materials, including the rights and responsibilities document, inform recipients about the choice to participate and obtain consent to participate.

BHH services providers will be expected to ensure that children and youth are cared for by team members who are specifically trained and experienced in working with children, youth and caregivers.

BHH services providers will be expected to maintain adequate staffing ratios listed to deliver the required services in a manner that best meets the needs of the individuals served.

If a provider serves 100 or less BHH recipients, the provider may utilize an adjusted staffing ratio of a minimum of .5FTE integration specialist and 1FTE systems navigator to serve these recipients. Upon recertification or upon serving more than 100 BHH recipients, these providers must meet and maintain the BHH staffing ratios listed in the payment section of the state plan amendment.

Teams will share a case load so that every consumer has access to the expertise and services provided by each of the three unique BHH services team members.

On an ongoing basis after the person's initial 90 days of receiving BHH services, the provider must:

• Have personal contact with the person or the person's identified support at least once per month. The contact must be connected to at least one of the six required services linked to the person's goals in the health action plan. This contact may include face-to-face, telephone contact or interactive video. A letter, voicemail, email or text alone does not meet the requirement for monthly personal contact. At a minimum, the BHH team must offer a face to face visit with the person every six months. If the person declines the offer of a face to face visit, the visit may be completed by telephone contact or interactive video.

Variance Authority:
The commissioner has authority to grant a variance of requirements related to behavioral health home services providers:

- Services provider requirements
- Services provider training and practice transformation requirements
- Services staff qualifications
- Services delivery standards

The variance may be granted if the commissioner finds that:
(1) failure to grant the variance would result in hardship or injustice to the applicant;
(2) the variance would be consistent with the public interest; and
(3) the variance would not reduce the level of services provided to individuals served by the organization.

The commissioner may also grant a variance from one or more requirements in the above subsections, to permit a services provider to offer behavioral health home services of a type or in a manner that is innovative, as long as there is no resulting impediment to achievements required by these subsection, and approval may improve services to the applicant.

Name	Date Created
No items available	

Health Homes Service Delivery Systems

Package ID	MN2022MS0006O	SPA ID	MN-22-0036
Submission Type	Official	Initial Submission Date	12/14/2022
Approval Date	02/03/2023	Effective Date	10/1/2022
Superseded SPA ID	MN-19-0015		

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- [ ] Fee for Service
- [ ] PCCM
- [ ] Risk Based Managed Care

The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals

- ( ) Yes
- (•) No

Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be avoided

- [ ] The current capitation rate will be reduced
- [ ] The State will impose additional contract requirements on the plans for Health Homes enrollees

Provide a summary of the contract language for the additional requirements

Behavioral health home services will be paid as part of the capitation rate, based on a rate set by the state. MCOs will not be a designated provider.

Contracts will include the following:

•The MCO is not permitted to reimburse the following services in the same calendar month that the member received behavioral health home services:
-assertive community treatment (ACT)
-youth assertive community treatment (Youth ACT)
-mental health targeted case management
-relocation services coordination
-health care homes care coordination
-targeted case management for persons not receiving services pursuant to a Section 1915(c) waiver who are vulnerable adults, adults with developmental disabilities, or adults without a permanent residence

•If an enrollee receives care management services from the MCO and BHH services in the same month, the MCO and the BHH must develop a written plan that defines the roles and responsibilities of the MCO care manager and the BHH team. The written plan must demonstrate that the minimal requirements for each entity are met and that duplication between the MCO and the BHH provider is avoided.

•The MCO must provide the BHH with a designated contact to facilitate the sharing of enrollee information and coordination of services.

•The MCO and the BHH must inform each other in a timely manner of any inpatient hospital admission or discharge to promote appropriate follow-up and coordination of services.

•The MCO and the BHH must inform each other in a timely manner of any use of the emergency department by the enrollee.

*For a person enrolled in a managed care plan, the BHH services provider will notify the BHH services contact designated by the managed care plan within 30 days of a person beginning receipt of services; and adhere to the managed care plan communication and coordination requirements described in the BHH services manual.

☐ Other

☐ Other Service Delivery System

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MN2024MS0003O | MN-24-0025 | Behavioral Health Homes

Package Header

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SPA ID MN-24-0025

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Initial Submission Date 7/30/2024

Approval Date 09/06/2024

Effective Date 7/1/2024

Superseded SPA ID MN-24-0008

Payment Methodology

The State's Health Homes payment methodology will contain the following features

☐ Fee for Service

☐ Individual Rates Per Service

☐ Per Member, Per Month Rates

☐ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☐ Other

Describe below

Per member per month rate as described below.

☐ Comprehensive Methodology Included in the Plan

☐ Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

The hourly costs for each professional are based on the salary and benefit expectations for each classification and assumptions around the professionals' time spent on the specific service integration activities. Salary expectations were based on comparable salaries within the existing DHS payment structure.

☐ PCCM (description included in Service Delivery section)

☐ Risk Based Managed Care (description included in Service Delivery section)

☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MN2024MS0003O | MN-24-0025 | Behavioral Health Homes

Package Header

Package ID	MN2024MS0003O	**SPA ID**	MN-24-0025
Submission Type	Official	**Initial Submission Date**	7/30/2024
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Superseded SPA ID	MN-24-0008		

Agency Rates

Describe the rates used

- (•) FFS Rates included in plan
- ( ) Comprehensive methodology included in plan
- ( ) The agency rates are set as of the following date and are effective for services provided on or after that date

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MN2024MS0003O | MN-24-0025 | Behavioral Health Homes

Package Header

Package ID	MN2024MS0003O	**SPA ID**	MN-24-0025
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Approval Date	09/06/2024	**Effective Date**	7/1/2024
Superseded SPA ID	MN-24-0008		

Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
    - the frequency with which the state will review the rates, and
    - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

Effective for services provided on or after January 1, 2024, payment for BHH services is $252.35 per member, per month. During the recipient's first six months of participation, the BHH will receive an enhanced payment rate of $360.50 per member, per month. This enhanced payment will be made only once in each recipient's lifetime.

Effective for annual adjustments to payment rates made on or after January 1, 2025, payments must be adjusted according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year.

The Department made the following assumptions in developing the monthly payment rates for behavioral health home services:

•The population served by the BHH services management team will have the need for varying level of services depending on the severity of the population's behavioral health conditions and medical comorbidities. Recipients are assigned to one of twelve different classification groups based on their age (children vs. youths vs. adults), the level of their medical comorbidities (no significant comorbidities, one to two medical risk indicators, three or more indicators of medical risk) and, for adults, the relative severity of their behavioral health condition (SMI vs. SPMI). The average rate is based on an assumed distribution of recipient classification based primarily on the existing behavioral and medical risk distribution of the population eligible for the program.

•The anticipated cost built into the rate for each activity is based on the number of expected hours for each activity, the distribution of the professionals assumed to be executing the activity and the expected hourly cost associated with the employment of those professionals.

•The relative amount of time spent on each management activity is based on review of comparable services at the state and national level, and survey information collected from potential participating organizations and groups currently performing similar management activities.

•Additional hours are also expected during the initial six months of a recipient's BHH receipt of services to allow for additional BHH activities during program acclimation.

•The expectation of monthly cost related to service integration is reduced after the recipient's first six months of BHH services. Specifically, there will be lower expected need for ongoing management once recipients are engaged in the program, their health action plans have been developed and implemented, and they have become acclimated to the program and the activities surrounding their health action plan.

•The multi-disciplinary service integration team is expected to complete specific BHH services requirements each month. The relative time spent by each professional varies by activity (i.e. the anticipated team composition for each activity varies based on the professional requirements necessary to execute the activity).

Additional detail around the assumptions used to develop the rates include:

•The monthly tasks and hours expectations are also differentiated by their assumed frequency. Some services are expected to occur on a monthly basis, whereas others are only attributable to the initial engagement period (e.g. health action plan development) or would be incurred on an "as-needed" basis for a portion of the population (e.g. management of

transitions of care). See below for highlights of the overall service integration requirements and the hourly assumptions for specific activities:
-Depending on recipient classification, the range of hours that it is anticipated that a BHH provider will spend on BHH services activities per month per recipient is 5 to 12.5 hours

>A recipient with SMI with low medical risk is assumed to require an average of 5 hours of monthly service integration, while a recipient with SPMI with high medical risk is assumed to need an average of 12.5 hours of monthly service integration activities

>Based on the expected distribution of recipients, the payment rate assumes an average of approximately 5.75 hours of monthly BHH activities.

-Beyond the initial health action plan development, each recipient's health action plan will be revised on a regular basis and time is incorporated into the monthly rates for these annual or semi-annual activities.

-The hours of service per month are estimated based on anticipated activities to achieve the behavioral health home goals and needs of the recipients. BHHs will not be required to report monthly hours for the purpose of payment.

The rate was developed with the assumption of a team-based approach that allows for each team member to complete specific activities connected to the six core health home services and to work at the top of their license or qualifications. The rate is built upon the following caseload ratios:

•1 FTE integration specialist for every 224 members
•1 FTE systems navigator for every 56 members
•1 FTE qualified health home specialist for every 56 members

The Department will allow a variance in the staffing ratios of up to 25 percent based on the needs and structure of the behavioral health home.

•The long-term staffing model assumes that new recipients (i.e. recipients requiring the management expectations used to develop the enhanced rate) will be 10% of the overall number of people receiving BHH services.

In order to receive a monthly PMPM payment, the BHH services provider must have personal contact with the person or the person's identified support at least once per month. The contact must be connected to at least one of the six required services linked to the person's goals in the health action plan. This contact may include face-to-face, telephone contact or interactive video. A letter, voicemail, email or text alone does not meet the requirement for monthly personal contact.

DHS will review BHH service rates at least every four years, as follows: DHS will review the Department of Labor prevailing wage for required team members, and average hours spent providing services; and will ensure that BHH rates are sufficient to allow providers to meet required certifications, training and practice transformation standards, staff qualification requirements, and service delivery standards.

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MN2024MS0003O | MN-24-0025 | Behavioral Health Homes

Package Header

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Assurances

☐ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved

Our MMIS system will prevent duplication of payment by preventing payment for the following services in the same month that a recipient receives behavioral health home services:

- assertive community treatment (ACT)
- youth assertive community treatment (Youth ACT)
- mental health targeted case management
- relocation services coordination
- targeted case management for persons not receiving services pursuant to a Section 1915(c) waiver who are vulnerable adults, adults with developmental disabilities, or adults without a permanent residence
- health care homes care coordination

Behavioral health home providers will refer recipients in need of ACT or Youth ACT services to a qualified provider of those services. The provision of BHH services will end once ACT/Youth ACT services commence.

Recipients of waiver services provided under § 1915(c) receive case management services to ensure access to services available under the waiver and to ensure effective utilization of these services. We will require BHH providers to coordinate service delivery with home and community based waiver case managers to ensure that no duplication occurs.

☐ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☐ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☐ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created

No items available

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MN2024MS0003O | MN-24-0025 | Behavioral Health Homes

Package Header

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Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

Comprehensive care management is a collaborative process designed to manage medical, social, and behavioral health conditions more effectively based on population health data and tailored to the individual recipient.

BHHs will:
•Design and implement new activities and workflows that increase recipient engagement and optimize efficiency.

•Use a searchable EHR tool and patient registry to collect individual and practice-level data. This will allow providers to identify, track, and segment the population, improve outcomes over time, manage BHH services, provide appropriate follow-up, and identify any gaps in care.

•Utilize population management, which is a proactive approach to using data to systematically assess, track, and manage health conditions of the recipient panel.

•Design and implement communication and care coordination tools, to ensure that care is consistent among a recipient's providers.

•Select common clinical conditions and target cohorts on which to focus.

•The integration specialist must review the patient registry regularly to track individuals' medications, lab results, support symptom management and use this data to discuss treatment with a recipient's primary care or behavioral health professional as needed. The registry must contain fields as determined by the Department.

•Meet with each recipient and evaluate their initial and ongoing needs.

•Utilize care strategies including HIT and other tools to communicate and coordinate with the recipient and with other caregivers.

•Monitor the use of routine and preventative primary care, dental care, and well-child physician visits.

When the recipient is a child or youth, all activities must include the child's parent/caregiver. The BHH must support the family in creating an environment to support their child in managing their health and wellbeing. For youth, the health action plan must address the plan to support transition from youth to adult services and supports.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All BHHs will be required to utilize electronic health records and a patient registry. Through the certification standards, behavioral health homes must demonstrate their capacity to collect data, exchange information, and monitor population health and to track progress and outcomes.

At a minimum, the BHH provider must:
•Use an electronic health record and patient registry to collect individual and practice-level data.

•Monitor and analyze data in their patient registry and in the tool approved by the Minnesota Department of Human Services to identify past and current treatment or services and identify potential gaps in care.

Behavioral health homes will be monitored on a regular basis to ensure adherence to certification standards.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants

- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Integration Specialist	These services are provided by a licensed nurse, including an advanced practice registered nurse, registered nurse, and a licensed practical nurse, when BHH service are offered in a mental health setting; or a mental health professional, as described in Attachment 3.1-A/B, item 6.d.A, when BHH services are offered in a primary care setting. These services may also be supported by other BHH team members.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MN2024MS0003O | MN-24-0025 | Behavioral Health Homes

Package Header

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Care Coordination

Definition

Care coordination occurs when the BHH acts as the central point of contact in the compilation, implementation, and monitoring of the individualized health action plan through appropriate linkages, referrals, coordination and follow-up to needed services and supports.

BHHs will perform:

Initial Assessment of Need
•Identify recipient's immediate safety and transportation needs and any other barriers to receiving BHH services.
•Implement a plan to meet immediate identified needs.

Health Wellness Assessment
•Complete the assessment using the guidance provided by the Department. The assessment process must begin within 30 days of intake and be completed within 60 days.
•Talk with BHH and other professionals involved in the recipient's care to gather information for the health action plan.
•The assessment must include a review of the diagnostic assessment, screenings for substance use, and the domains identified in the comprehensive wellness inventory created by the state.

Development of Health Action Plan
•Draft a patient-centered health action plan based on the comprehensive inventory within 90 days of intake. BHHs must use the health action plan guidance provided by the Department.
•Update the health action plan at least every six months thereafter.

Ongoing Care Coordination
•Maintain regular and ongoing contact with the recipient and/or their identified supports.
•Monitor progress on goals in the health action plan and the need for plan alterations.
•Assist the recipient in setting up and preparing for appointments, accompanying the recipient to appointments as appropriate, and follow-up.
•Identify and share individual-level information with professionals involved in the individual's care.
•Ensure linkages to medication monitoring as needed.
•Coordinate within the BHH team on behalf of the recipient.

When the recipient is a child or youth, all activities must include the child's parent/caregiver.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All BHHs will be required to utilize electronic health records and a patient registry. Through the certification standards, behavioral health homes must demonstrate their capacity to collect data, exchange information, and monitor population health and to track progress and outcomes.

At a minimum, the BHH provider must:
•Use an electronic health record and patient registry to collect individual and practice-level data.

•Monitor and analyze data in their patient registry and in a population health management tool, approved by the Minnesota Department of Human Services, to identify past and current treatment or services and identify potential gaps in care.

Additional HIT-related requirements that will be phased in over the first 18 months include:

•Use of HIT to link services, identify and manage gaps in care, track, and segment the population, and improve outcomes over time.

•Use of electronic and non-electronic tools to use best practices and evidence to guide care.

•Use of HIT to facilitate communication among behavioral health home team members and other providers and with the recipient and with other caregivers.

Behavioral health homes will be monitored on a regular basis to ensure adherence to certification standards.

Scope of service

The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses
- ☐ Medical Specialists
- ☐ Physicians
- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☐ Other (specify)

Provider Type	Description
Behavioral Health Home Systems Navigator	Care coordination services are provided by either a mental health practitioner as defined in Attachments 3.1-A/B, item 4.b, or community health worker. These services may also be supported by other BHH team members.

Health Homes Services

Package Header

Package ID	MN2024MS0003O	**SPA ID**	MN-24-0025
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Health Promotion

Definition

Health and wellness promotion services encourage and support healthy living and motivate individuals and/or their identified supports to adopt healthy behaviors and promote better management of their health and wellness. They place a strong emphasis on skills development so individuals and/or their identified supports can monitor and manage their chronic health conditions to improve health outcomes.

BHHs will be responsible to:
•Provide recipients with information to increase their understanding of the illnesses/health conditions identified in the health wellness assessment, and educate recipients on how those conditions relate to and impact various facets of their health and well-being.

•Work with recipients to increase their knowledge about their specific health conditions and support recipients in developing skills to self-manage their care and maintain their health.

•Support recipient participation in activities aimed at developing skills to self-manage their care and reach their health goals.

•Support recipients in recovery and resiliency.

•Offer or facilitate the provision of on-site coaching, classes, and information on topics related to the identified needs of recipients, including: wellness and health-promoting lifestyle interventions, substance use disorder prevention/early intervention and cessation, HIV/AIDS prevention/early intervention, STD prevention/early intervention, family planning and pregnancy support, nicotine prevention and cessation, nutritional counseling, obesity reduction and prevention, increasing physical activity, and skill development.

When the recipient is a child or youth, all activities must include the child's parent/caregiver. The BHH must support the family in creating an environment to support their child in managing their health and wellbeing. For youth, the health action plan must address plan to support the transition from youth to adult services and supports.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All BHHs will be required to utilize electronic health records and a patient registry. Through the certification standards, behavioral health homes must demonstrate their capacity to collect data, exchange information, and monitor population health and to track progress and outcomes.

At a minimum, the BHH provider must:
•Use an electronic health record and patient registry to collect individual and practice-level data.

•Monitor and analyze data in their patient registry and in the Minnesota Department of Human Services tool to identify past and current treatment or services and identify potential gaps in care.

Additional HIT-related requirements that will be phased in over the first 18 months include:

•Use of HIT to link services, identify and manage gaps in care, track, and segment the population, and improve outcomes over time.

•Use of electronic and non-electronic tools to use best practices and evidence to guide care.

•Use of HIT to facilitate communication among behavioral health home team members and other providers and with the recipient and with other caregivers.

Behavioral health homes will be monitored on a regular basis to ensure adherence to certification standards.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Qualified Health Home Specialist	Health promotion services are provided by either a: • Case management associate as defined in Attachment 3.1-A/B, supplement 1. • Mental health rehabilitation worker as defined in Attachment 3.1-A/B, item 13.d. • Community health worker • Mental health certified peer support specialist as defined in Attachment 3.1-A/B, item 13.d. • Mental health certified family peer support specialist as defined in Attachment 3.1-A/B, item 4.b. • Community paramedic as defined in Attachment 3.1-A/B, item 5.a. • Qualified substance use disorder peer recovery specialist. These services may also be supported by other BHH team members.

Health Homes Services

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Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive transitional care activities are specialized care coordination services that focus on the movement of recipients between different levels of care or settings. The BHH will:

•Ensure recipient services and supports are in place:
-Following discharge from a hospital or treatment center;
-Following departure from a homeless or domestic violence shelter, a correctional facility, foster care, and any other setting with which the recipient and family may be involved.
-In conjunction with children and family services, treatment foster care, special education and other services with which the recipient and family may be receiving.

•In partnership with the recipient and their identified supports, establish a transition plan to be followed after discharge from hospitals, residential treatment, and other settings. The plan should be in place prior to discharge, when possible, and should include protocols for:
-Maintaining contact between the BHH and the recipient and their identified supports during and after discharge;
-Linking recipients to new resources as needed;
-Reconnecting to existing services and community and social supports; and
-Following up with appropriate entities to transfer or obtain recipient's service records as necessary for continued care.

•Develop relationships with local hospitals and inform them of the opportunity to connect existing In-reach services to BHH.

•Advocate on behalf of the recipient and their families to ensure they are included in transition planning. When the recipient is a child or youth, all activities must include the recipient's family or identified supports.

BHHs must:
•Ensure plans are developmentally appropriate

•Ensure plans include the parent/caregiver.

•Collaborate with the parent/caregiver in all discharge planning.

•Ensure that the parent/caregiver has adequate information about the children's condition to support the child and family in self-management.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All BHHs will be required to utilize electronic health records and a patient registry. Through the certification standards, behavioral health homes must demonstrate their capacity to collect data, exchange information, and monitor population health and to track progress and outcomes.

At a minimum, the BHH provider must:
•Use an electronic health record and patient registry to collect individual and practice-level data.

•Monitor and analyze data in their patient registry and in the Minnesota Department of Human Services tool to identify past and current treatment or services and identify potential gaps in care.

Additional HIT-related requirements that will be phased in over the first 18 months include:

•Use of HIT to link services, identify and manage gaps in care, track, and segment the population, and improve outcomes over time.

•Use of electronic and non-electronic tools to use best practices and evidence to guide care.

•Use of HIT to facilitate communication among behavioral health home team members and other providers and with the recipient and with other caregivers.

Behavioral health homes will be monitored on a regular basis to ensure adherence to certification standards.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Behavioral Health Home Systems Navigator	This service is provided by either a mental health practitioner as defined in Attachments 3.1-A/B, item 4.b, or community health worker. This service may also be supported by other BHH team members.

Health Homes Services

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Individual and Family Support (which includes authorized representatives)

Definition

Individual and family support services are activities, materials, or services aimed to help recipients reduce barriers to achieving goals, increase health literacy and knowledge about chronic condition(s), increase self-efficacy skills, and improve health outcomes.

The BHH will:
•Provide person-centered, consistent, and culturally-appropriate communication with recipients and their identified supports.

•Accurately reflect the preferences, goals, resources, and optimal outcomes of the recipient and their identified supports in the creation of the health action plan

•Utilize the recipient's formal and informal supports as chosen by the individual, to assist in the recipient's recovery, promote resiliency, and support progress toward meeting the recipient's health goals.

•Assist recipients and families with accessing self-help resources, peer support services, support groups, wellness centers, and other care programs focused on the needs of the recipient and his or her family and/or identified supports.

•Assist recipients with obtaining and adhering to prescribed medication and treatments.

•Offer family support and education activities.

•Support recipients and/or recipients' identified supports in improving their social networks.

•Teach individuals and families how to navigate systems of care in order to identify and utilize resources to attain their highest level of health and functioning within their families and community.

When the recipient is a child or youth, all activities must include the child's parent/caregiver.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All BHHs will be required to utilize electronic health records and a patient registry. Through the certification standards, behavioral health homes must demonstrate their capacity to collect data, exchange information, and monitor population health and to track progress and outcomes.

At a minimum, the BHH provider must:
•Use an electronic health record and patient registry to collect individual and practice-level data.

•Monitor and analyze data in their patient registry and in the Minnesota Department of Human Services Partner tool to identify past and current treatment or services and identify potential gaps in care.

Additional HIT-related requirements that will be phased in over the first 18 months include:

•Use of HIT to link services, identify and manage gaps in care, track, and segment the population, and improve outcomes over time.

•Use of electronic and non-electronic tools to use best practices and evidence to guide care.

•Use of HIT to facilitate communication among behavioral health home team members and other providers and with the recipient and with other caregivers.

Behavioral health homes will be monitored on a regular basis to ensure adherence to certification standards.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Behavioral Health Home Systems Navigator	This service is provided by either a mental health practitioner as defined in Attachments 3.1-A/B, item 4.b, or community health worker. This service may also be supported by other BHH team members.

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Referral to Community and Social Support Services

Definition

Referral to community and social support services occurs in collaboration with the recipient and/or their identified supports.

The BHH provider:
•Identifies appropriate resources,

•Refers recipients to a variety of services,

•Assists recipients in setting up and preparing for appointments, and

•Accompanies the recipient to appointments as appropriate.

The BHH will:
•Have a process in place to learn about and understand the
recipient's culture and individual preferences and include the recipient in identifying resources that meet their cultural needs.

•Ensure that recipients have access to resources in order to address the recipient's identified goals and needs. Resources should address social, environmental and community factors all of which impact holistic health; including but not limited to, medical and behavioral health care, entitlements and benefits, respite, housing, transportation, legal services, educational and employment services, financial services, long term supports and services, wellness and health promotion services, specialized support groups, substance use prevention and treatment, social integration and skill building, and other services as identified by the recipient and their identified supports.

•Check in with the recipient and their family after a referral is made in order to confirm if they need further assistance scheduling or preparing for appointments, or assistance following up after connecting with community resources.

•Develop and maintain relationships with other community and social support providers to aid in effective referrals and timely access to services.

Adult recipients will be encouraged to identify family or other supports to participate in BHH services. When the recipient is a child or youth, BHHs must include the parent/caregiver in activities and ensure resources are developmentally appropriate.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All BHHs will be required to utilize electronic health records and a patient registry. Through the certification standards, behavioral health homes must demonstrate their capacity to collect data, exchange information, and monitor population health and to track progress and outcomes.

At a minimum, the BHH provider must:
•Use an electronic health record and patient registry to collect individual and practice-level data.

•Monitor and analyze data in their patient registry and in the Minnesota Department of Human Services tool to identify past and current treatment or services and identify potential gaps in care.

Additional HIT-related requirements that will be phased in over the first 18 months include:

•Use of HIT to link services, identify and manage gaps in care, track, and segment the population, and improve outcomes over time.

•Use of electronic and non-electronic tools to use best practices and evidence to guide care.

•Use of HIT to facilitate communication among behavioral health home team members and other providers and with the recipient and with other caregivers.

Behavioral health homes will be monitored on a regular basis to ensure adherence to certification standards.

Scope of service

The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses
- ☐ Medical Specialists
- ☐ Physicians
- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☐ Other (specify)

Provider Type	Description
Behavioral Health Home Systems Navigator	This service is provided by either a mental health practitioner as defined in Attachments 3.1-A/B, item 4.b, or community health worker. This service may also be supported by other BHH team members.

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Health Homes Services

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Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

See attached documents.

Name	Date Created	
BHH Macro Map Submission	8/16/2016 5:12 PM EDT	
BHH Micro Map Submission	8/16/2016 5:12 PM EDT	

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | MN2024MS0004O | MN-24-0035 | Behavioral Health Homes

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Package ID	MN2024MS0004O	**SPA ID**	MN-24-0035
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Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates:

The Department will use data from FFS claims and encounter data to estimate the savings achieved. We will compare the relative claim costs and annual cost increases of the BHH enrolled population to the overall Medicaid population and the "control" population of the BHH-eligible members who are not enrolled in a BHH. The observed relative costs and year-to-year trends will be reasonably adjusted for the populations' relative Medicaid program distributions and risk (i.e. risk adjusted) and, for the BHH-enrolled vs. control group comparison, the classification of the member (SED, SMI, SPMI, etc.). The Department will also measure the relative costs by broad and detailed claim cost categories to understand the key drivers of the observed aggregate savings and provide additional feedback to the participating providers. Where appropriate, the Department may choose to adjust for the impact of high-cost cases, although the relative prevalence of high-cost cases will likely be retained as part of the overall performance assessment. Where sufficient enrolled lives exist to develop credible estimates, the Department may also choose to examine the cost savings achieved by individual BHHs.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

All BHHs will be required to utilize electronic health records and a patient registry. Through the certification standards, behavioral health homes must demonstrate their capacity to collect data, exchange information, and monitor population health and to track progress and outcomes.

At a minimum, the BHH provider must:
•Use an electronic health record and patient registry to collect individual and practice-level data.

•Monitor and analyze data in their patient registry and in a tool approved by the Minnesota Department of Human Services to identify past and current treatment or services and identify potential gaps in care.

Additional HIT-related requirements that will be phased in over the first 18 months include:

•Use of HIT to link services, identify and manage gaps in care, track, and segment the population, and improve outcomes over time.

•Use of electronic and non-electronic tools to use best practices and evidence to guide care.

•Use of HIT to facilitate communication among behavioral health home team members and other providers and with the recipient and with other caregivers.

Behavioral health homes will be monitored on a regular basis to ensure adherence to certification standards.

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | MN2024MS0004O | MN-24-0035 | Behavioral Health Homes

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Superseded SPA ID	MN-19-0015		

Quality Measurement and Evaluation

X The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state.

X The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.

X The state provides assurance that it will report to CMS information to include applicable mandatory Core Set measures submitted by Health Home providers in accordance with all requirements in 42 CFR §§ 437.10 through 437.15 no later than state reporting on the 2024 Core Sets, which must be submitted and certi ed by December 31, 2024 to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS. In subsequent years, states must report annually, by December 31st, on all measures on the applicable mandatory Core Set measures that are identified by he Secretary.

X The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report.

1915(i) State plan Home and Community-Based Services

*** **Note**: This section is intentionally left blank and has been deleted effective November 1, 2025

1915(i) State plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. **Services.** *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

The services provided under the Community First Services and Supports benefit are :
(1) Personal Care Assistance
(2) Personal Emergency Response Systems (PERS)
(3) Individual Directed Goods and Services
(4) Financial Management Services

2. **Concurrent Operation with Other Programs.** *(Indicate whether this benefit will operate concurrently with another Medicaid authority):* ***Select one*:**

☐	**Not applicable**
☒	**Applicable**
Check the applicable authority or authorities:	
☒	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1):* BluePlus, HealthPartners, Itasca Medical Care, Medica, Prime West Health, South Country Health Alliance, UCare[1] *(b) the geographic areas served by these plans:* See map of plan choices by county https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4840-ENG *(c) the specific 1915(i) State plan HCBS furnished by these plans:* Personal Care Assistance, Personal Emergency Response Systems (PERS), Individual Directed Goods and Services and Financial Management Services. *(d) how payments are made to the health plans:* Payments are made through capitations. *(e) whether the 1915(a) contract has been submitted or previously approved:* Upon approval of this state plan amendment, Minnesota Senior Health Options (MSHO) contracts will be amended to include the revised services.

☒	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:* The 1915(b) waiver application for Minnesota Senior Care Plus (MSC+) program will be submitted in conjunction with this 1915(i) application.

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

☒	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)

☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*
☐	**A program authorized under §1115 of the Act.** *Specify the program*:

[1] These plans are known as Minnesota Senior Health Options (MSHO) plans with voluntary enrollment for duals. These plans will also incorporate the 1915(i) benefit.

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit- *(Select one):*

☒ The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:

☒	The Medical Assistance Unit *(name of unit)*:	Health Care Administration
☐	Another division/unit within the SMA that is separate from the Medical Assistance Unit *(name of division/unit)* *This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.*	

☐ The State plan HCBS benefit is operated by *(name of agency)*

a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.

4. Distribution of State plan HCBS Operational and Administrative Functions.

☒ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approvespolicies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☑	☑
2 Eligibility evaluation	☑	☐	☐	☐
3 Review of participant service plans	☑	☐	☑	☑
4 Prior authorization of State plan HCBS	☑	☐	☑	☑
5 Utilization management	☑	☐	☐	☐
6 Qualified provider enrollment	☑	☐	☐	☐
7 Execution of Medicaid provider agreement	☑	☐	☐	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
10 Quality assurance and quality improvement activities	☑	☐	☐	☐

Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Function 1: Individual State plan HCBS enrollment:

County agencies and tribal human services agencies under interagency agreement with the SMA are the local non-state entities that assist individuals not enrolled in an MCO with enrolling in HCBS.

Managed care organizations (MCO) are the contracted entities that assist individuals aged 65 and over who are enrolled in managed care to enroll in HCBS.

Function 3: Review of participant service plans:

Consultation service providers are the contracted entities that conduct an initial review of service plans for all individuals electing the benefit. In supporting the person, they will review whether the plan meets assessed needs and contains only covered services.

County agencies and tribal human services agencies under interagency agreement with the SMA are the local non-state entities that review service plans for participants not enrolled in an MCO. The state Medicaid agency provides oversight of counties and tribal human services agencies through lead agency audits and reviews. The review process includes an audit of a representative sample of approved service plans. For more information on this process please see the section on the Process for Making Person-Centered Service Plans Subject to the Approval of the Medicaid Agency section.

Managed care organizations (MCO) are the contracted entities that review participant service plans for individuals aged 65 and over who are enrolled in managed care. The state Medicaid agency provides oversight of MCOs through audits and reviews of a representative sample of approved service plans. For more information on this process, please see the section on the Process for Making Person-Centered Service Plans Subject to the Approval of the Medicaid Agency section.

Function 4: Prior authorization of state plan HCBS:

Counties agencies and tribal human services agencies under interagency agreement with the SMA are the local non-state entities that conduct prior authorizations of HCBS for those not enrolled in an MCO.

Managed care organizations (MCO) are the contracted entities that conduct prior authorization of state plan HCBS for individuals age 65 and over who are enrolled in managed care.

(By checking the following boxes the State assures that):

5. ☒ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations,assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

The SMA retains oversight for all operational and administrative functions and ensures adherence to the regulatory requirements set forth in 42 C.F.R. § 441.730(b).

Consultation service providers are the entity contracted with the SMA that furnish supports to individuals to develop their person-centered service delivery plan (plan of care). Only these entities may provide consultation services. All individuals are advised of their right to choose any contracted consultation service provider. Consultation service providers must comply with conflict-of-interest standards as outlined in their contract and provided in federal and state law.

Agencies that provide Consultation Services may also enroll to provide Medicaid services. However, Consultation service providers are prohibited from providing any other service to any individual they serve under consultation services.

The Consultation Service provider must notify each individual in writing that it cannot provide any other service to that individual. Consultation service providers must sign an assurance statement to ensure adherence with conflict-of-interest provisions.

SMA oversight is provided through contract monitoring, training, policy direction, enrollment criteria and service plan audits as outlined in this SPA.

The SMA conducts audits annually at the Consultation service provider level as outlined in the Quality Improvement section of this SPA. Audits include a review of service delivery plans to ensure they contain required elements and ensure required conflict of interest provisions are applied.

Additional participant safeguards related to conflicts of interest include:

- conflict of interest protections outlined in state statute related to person-centered planning;
- individuals are supported in exercising free choice of provider and are provided information on the full range of 1915(i) services; and
- individuals are educated on rights and protections related to development of their person-centered plan.

6. ☒ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☒**No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☒**Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.** *(Specify for year one. Years 2-5 optional):*

Annual Period	From	To	Projected Number of Participants
Year 1	10/01/2024	09/30/2025	2957
Year 2			
Year 3			
Year 4			
Year 5			

2. ☒**Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☒ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☐ The State does not provide State plan HCBS to the medically needy.

☒ The State provides State plan HCBS to the medically needy. (*Select one*):

☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.

☒ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) ofthe Social Security Act.

Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

☒	Directly by the Medicaid agency
☐	By Other (*specify State agency or entity under contract with the State Medicaid agency*):

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The SMA developed and manages a comprehensive electronic assessment tool, referred to as MnCHOICES, that must be used for evaluating whether individuals meet the needs-based eligibility criteria for this benefit.

The policy staff at the SMA responsible for developing the eligibility rules within the MnCHOICES system must have extensive knowledge and expertise in Home and Community Based Services. Individuals must have a bachelor's degree in psychology, social work, education, public health, nursing or a closely related field, or equivalent experience. Individuals must have experience in or complete training on the eligibility requirements for this benefit and the assessment process. Individuals must have a comprehensive understanding of the regulatory requirements related to the assessment process and benefit eligibility criteria.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

In order to make a determination regarding eligibility and reevaluation of eligibility, both of the following criteria must be evaluated:

- Financial eligibility for 1915(i); and
- Needs-based eligibility for 1915(i).

Financial eligibility determinations are made by counties and tribal human services agencies as delegates of the SMA utilizing standardized tools provided, managed and overseen by the SMA. Employees making financial eligibility determinations are county or tribal human services agency employees, titled "eligibility workers". Information regarding financial eligibility is collected and entered into the Medicaid Management Information System (MMIS).

The SMA developed and manages a comprehensive electronic assessment tool, referred to as MnCHOICES, that must be used for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria.

SMA trained and certified assessors meet with individuals to compete the tool. The information from the tool is analyzed using a set of algorithms to determine whether the person meets the eligibility criteria for this benefit.

The MnCHOICES system also includes program edits to validate financial eligibility data from the MMIS system to the MnCHOICES system. This allows the SMA to make a final eligibility determination.

The SMA maintains authority over the process and determinations cannot be overridden by an assessor. The SMA also conducts quality reviews of the data to evaluate inter-rater reliability and compliance with the requirements. There is no difference in the process for initial evaluations and reevaluations, with the following exception:

- SMA county exception for areas where the electronic component of the MnCHOICES assessment tool is not currently in use for eligibility reevaluations. County assessors in certain areas of the state may use a partially automated version of the SMA's assessment tool for gathering information for eligibility reevaluations of fee-for-service (FFS) participants. The county assessors completing these FFS reassessments must be Registered Nurses with a Public Heath certificate. They may be certified assessors, but it is not required. The county assessors enter participants' reassessment information into MMIS and programming edits apply. The SMA is permitting a limited number of counties to use the partially automated process for a transition period that is projected to be completed by September 30, 2024. Under the SMA county exception, the SMA continues to make final determinations of program eligibility through Medicaid Management Information System (MMIS) programming and other oversight activities as outlined in both the conflict of interest and QIS sections of this SPA.

4. ☒ **Reevaluation Schedule.** *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☒ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

These 1915(i) benefits are available to participants who require hands-on assistance, or constant supervision and cueing, to accomplish one or more activities of daily living and do not meet an institutional level of care. *Individuals whose needs meet an institutional level of care will be served under a 1915(c) waiver or the 1915(k) benefit.*

6. ☒ **Needs-based Institutional and Waiver Criteria.** (By checking this box the state assures that): There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based criteria	*NF (& NF LOC** waivers)*	*ICF/IID (& ICF IID LOC waivers)*	*Applicable Hospital* (& Hospital LOC waivers)*
Require hands-on assistance, or constant supervision and cueing, to accomplish one or more activities of daily living and do not meet an institutional level of care. *Individuals whose needs meet an institutional level of care will be served under a 1915(c) waiver or the 1915(k) benefit.*	For NF level of care, the participant must meet one of the five categories of need below: 1. Does/would live alone or be homeless without current housing type and meets one of the following criteria: a. Has had a fall resulting in a fracture within the last 12 months b. Has a sensory impairment that substantially impacts functional ability and maintenance of a community residence c. Is at risk of maltreatment or neglect by another person, or is at risk of self-neglect 2. Requires assistance and is dependent in four or more activities of daily living (ADLs)	Be unable to apply skills learned in one environment to another (i.e., cannot generalize skills to "real world" situations) Have a diagnostic determination of intellectual or developmental disability or a related condition Require a continuous program of aggressive, systemic instruction and supervision (i.e., active treatment) to participate in life activities Require a 24-hour plan of care based on need for active treatment to gain and/or maintain the highest level of self-sufficiency and life participation.	Have both predictable health needs and the potential for status changes that could lead to rapid deterioration or life-threatening episodes because of the participant's health condition Require professional nursing assessments and intervention multiple times during a 24-hour period to maintain and prevent deterioration of health status Require a 24-hour plan of care, including a back-up plan, to reasonably ensure health and safety in the community Require frequent or continuous care in a hospital.

	3. Has significant difficulty with memory, using information, daily decision-making or behavioral needs that require intervention 4. Requires assistance and is dependent on another person to complete ADLS that cannot be scheduled (toileting, transferring or positioning) or 5. Needs formal clinical monitoring at least once a day.		

**Long Term Care*
***LOC= level of care*

7. ☐ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. *(Specify the phase-in plan):*

(By checking the following box the State assures that):

8. ☒ **Adjustment Authority.** The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, **and** (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services.** The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*: one or more services*
ii.	**Frequency of services.** The state requires (select one):
☒	**The provision of 1915(i) services at least monthly**
☐	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☒ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

(Note: In the Quality Improvement Strategy [QIS] portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home andcommunity-based settings requirements, at the time of this submission and ongoing.

The HCBS provider does not own/control the setting in which the participant resides. Therefore, they do not meet the regulatory definition of "provider-owned or controlled" as set forth in 42 C.F.R. § 441.710(a)(1)(vi).

The HCBS provider does not have a direct or indirect financial relationship with the property owners in the settings described below. Therefore, the nature of the relationship does not affect either the care provided or the financial conditions applicable to tenants. Participants do not need to use a specific HCBS provider in order to live in the residence.

This is a participant-controlled method of selecting and providing services and supports that allows the participant maximum control of the services and supports.

Although the HCBS provider does not own/control the setting, person-centered planning remains an important protection to assure that individuals have opportunities for full access to the greater community to the same degree as individuals not receiving Medicaid HCBS.

Residential setting types in which an individual may receive services under the HCBS benefit include:

1. Participants may receive services in their own home or family home.

   A participant's own home is defined as a single-family home or unit in a multi-family home (e.g. apartment) where a participant lives, and the participant or their family owns/rents and maintains control over the individual unit, demonstrated by a lease agreement (if applicable).

2. Participants may receive services in residential settings that are not controlled by the provider of HCBS. These include:
   - Settings registered by the Minnesota Department of Health (MDH) as a board and lodge establishment (e.g. hotel, VRBO, etc.)
   - Board and Lodge: The HCBS provider is a separate and distinct provider from the entity that owns/operates the board and lodge setting and/or provides services under Minn. Stat. 157.17. The entity that operates the board and lodge and/or provides services under Minn. Stat. 157.17 is not being paid to provide HCBS. This entity is registered by the MN Department of Health and can designate whether they provide special services. Individuals receiving special services in this setting would not be eligible for HCBS.

HCBS will not be provided in non-residential waiver provider-controlled settings such as day service facilities or adult day centers.

The following strategies will be used to assure ongoing compliance with home and community-based service requirements for the provision of HCBS for the types of settings described under residential setting types above:

- An individual's place of residence is verified at the time services are authorized and the counties, tribal human services agencies, and MCOs determine whether they are residing in a setting in the community in which HCBS are allowed.
- Personal Care Support workers complete required person-centered training as part of worker training and development for both the agency and budget models
- Agency providers complete initial HCBS training which includes person-centered practices, as well as service and protection related rights
- Funded as a Medicaid administrative activity under a CMS approved cost allocation plan, the Consultation Service provider assists participants with the following:
  a. Offer choices to the participant regarding the services and supports they receive (and from whom) and record the alternative home and community-based settings that were considered by the participant in their service plan
  b. Educate participants on HCBS expectations and person-centered practices and their service/protection related rights upon initial orientation and annual review
- Participants are surveyed annually on their experience with HCBS to assure person-centered practices are being followed and their rights are asserted and protected. (The SMA will use survey results to trigger remediation at an individual level when a participant's experience differs from HCBS requirements).
- Agency providers attest to compliance with home and community-based services requirements as part of new enrollment (new provider record), re-enrollment (inactive to active) or revalidation every three years (review of enrollment documents of currently active record) as a Medicaid provider.

Program-monitoring metrics are cited in the quality assurance sections later in this document that assure compliance with HCBS settings requirements.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☒ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☒ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☒ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

An assessor performs face-to-face assessments of an individual's support needs and capabilities. Assessors complete training and a certification developed by the SMA and are required to be recertified every three years.

Assessors are people with a minimum of a bachelor's degree in social work, nursing with a public health nursing certificate or other closely related field. They must have at least one year of home and community-based experience or be a registered nurse with at least two years of home and community-based experience with training and certification specific to assessment and consultation for long-term care services in the state.

5. **Responsibility for Development of Person-Centered Service Plan.** There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

The individualized, person-centered service delivery plan is developed with the active engagement by the participant/representative with support from the consultation services provider (an administrative activity in accordance with the state's CMS approved Medicaid cost allocation plan).

Consultation service providers assist the participant with understanding the benefit, planning for services, choosing a model, and then creating and implementing the participant's service delivery plan.

A consultation services provider agency must:

- Be enrolled as a provider in accordance with state Medicaid agency requirements
- Employ at least one lead staff member who meets the qualifications for the lead employee
- Have the ability to provide services statewide (either in person or remotely)
- Have an office located in Minnesota;
- Have a toll-free phone number and secure fax number;
- Have never had a lead agency contract or provider agreement discontinued due to fraud;
- Have never been disqualified under the criminal background check system; and
- complete all SMA-mandated training applicable to their roles

Consultation Service provider agencies must employ at least one lead professional staff that is required to meet at least one of the following education requirements:

- Be a Doctor of Medicine or osteopathy
- Be a registered nurse; or
- Have a bachelor's degree or higher in one ofthe following fields:
  - Occupational therapist
  - Physical therapist
  - Psychologist
  - Social worker
  - Speech-language pathologist or audiologist
  - Professional recreation staff
  - Professional dietitian
  - Have a designation as a human services professional

The lead professional staff must also have at least one year of experience working directly with people who have an intellectual disability or other developmental disability and have a degree in a discipline associated with at least one of the following fields of study:

- Human behavior (e.g., psychology,sociology, speech communication, gerontology, etc.);
- Human skill development (e.g., education,counseling, human development);
- Humans and their cultural behavior (e.g., anthropology);
- The human condition (e.g., literature, art); or
- Any other study of services related to basic human care needs (e.g., rehabilitation counseling).

Additionally, the lead professional staff must:

- Be 18 years old or older;
- Clear a background study as required under Minnesota Statutes, Chapter 245C; and
- Have a minimum of two years of full-time experience in the field of self-direction.

Staff members working directly with participants (but not as the lead professional staff of a consultation services provider) must meet the education requirements listed in the lead professional staff education section or meet the education substitution. These staff members can substitute one of the following for a bachelor's degree:

- Experience coordinating or directing services for people with disabilities or people older than age 65, including self-directed services; or
- Experience coordinating their own services.

Anyone working under the lead professional staff must also:

- be 18 years or older; and
- have a completed background study.

6. **Supporting the Participant in Development of Person-Centered Service Plan.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

Participants and/or their representative are actively engaged in the development of the person-centered service delivery plan with the support of a consultation services provider. The assessor will provide needs assessment results to the consultation service provider, FMS and/or service agency, as applicable.

(a) After the needs assessment, the assessor offers the participant the choice of a consultation service provider to support the individual to develop their person-centered service delivery plan. The participant chooses a consultation service provider to provide them with information about the service models, rights and responsibilities including appeal rights, choice in providers, service policy and budget information for those who choose the budget model. The consultation service provider also provides the participant with the service delivery plan template and provides support to develop the plan as directed by the participant. The support provided by consultation services is outlined in further detail below.

Consultation Services (An Administrative Activity)

This service provides necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions. Components of this support include providing voluntary training on how to select, manage and dismiss personal care support workers.

Consultation service providers will:

- Educate the participant about service options;
- Educate the participant about choices in providers;
- Educate the participant about rights and responsibilities (including appeal rights);
- Educate the participant about the agency model and budget model;
- Assure a person-centered planning process;
- Help the participant or the participant's representative write, implement and evaluate their service delivery plan (to the extent the participant desires);
- Assist participants who have chosen the budget model with developing a budget;
- Provide the participant with a list of service agency providers (if the participant chooses the agency model) or financial management services (FMS) providers (if the participant chooses the budget model);
- Train the participant to recruit, select, train, schedule, supervise, direct, evaluate and dismiss personal care support workers including assistance as desired with development of worker training and development plans within the service delivery plan;
- Respond to participant's questions related to self-directed tasks or other concerns throughout the service delivery plan year;
- Complete a semi-annual review if their spouse or parent (if a minor) serves as their personal care support worker; and
- Revise a person-centered service delivery plan to achieve quality service outcomes.

When a participant uses the budget model, the consultation services provider will provide these additional duties:

- Monitor the participant's success in using the budget model and re-educate and/or recommend involuntary exit, if needed;
- Work with the FMS provider to provide the participant with ongoing support to serve as the employer of their personal care support workers;
- Check in with the participant to ask if they are completing employer tasks, such as:
  - Ensuring the support workers are competent to meet the participant's needs, including assistance with changes to worker training and development plan as needed;
  - Orienting and training support workers;
  - Evaluating support workers within 30 days of hire, the start of a new plan year or after a change in condition;
  - Verifying and maintaining evidence of support worker competency, including documentation;
  - Completing support worker performance reviews at least once per year; and
  - Answering the participant's questions during check-ins.

The consultation service provider will maintain and document routine communication with the participant to review
services and plan implementation. The participant has the option to request additional ongoing support from the consultation service provider when needed. This may occur when the participant chooses to change their plan or they have a change in condition that needs to be addressed in the plan. A participant using the budget model may also request support from the consultation service provider to assist with understanding their role as the employer.

Consultation service providers provide additional support if a participant is not carrying out their duties under the budget-model. The consultation service provider will develop an individualized plan to provide additional training, check-ins or other assistance to ensure the participant is completing employer tasks. The consultation service provider will document outcomes of the additional supports and training, and may recommend involuntary
exit to SMA/county, tribal human services agency, or MCO, if needed.

Additional responsibilities and expectations of consultation service providers include:

- Helping SMA/counties, tribal human services agencies, and MCO with surveys and data collection, upon request;
- Documenting complaints received for possible audit;
- Implementing policies and procedures to meet the needs of culturally diverse participants receiving services;
- Reviewing grievance policies annually;
- Sharing information from SMA/county, tribal human services agency, or MCO (e.g., policy clarifications or changes) with participants when requested by the SMA;
- Complying with all other requirements, as applicable.

(b) The participant, or their representative, is responsible for writing the service delivery plan with the support of the consultation services provider to the extent desired by the participant. The participant may choose other people who are important to supporting them (for example, to be active in their community and/or meeting their assessed needs), to participate in the service delivery plan development process. This could include the representative, family members, friends, natural supports or others.

7. **Informed Choice of Providers.** ***(****Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

After the needs assessment, the assessor offers the participant the choice of a consultation service provider to support the individual to develop their person-centered service delivery plan. The consultation services provider shares information on how to recruit, select, train, schedule, supervise, direct, evaluate and dismiss personal care support workers. Consultation service providers will also direct participants to MinnesotaHelp.info (https://MinnesotaHelp.info) or the MCO provider network. This site contains a listing of qualified service agencies and personal care support workers. The consultation services provider will answer any questions and help perform a search of available providers.

8. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency.

(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):

The participant, or their representative, are actively engaged in the development of the service delivery plan with assistance of consultation services as requested.

For purposes of developing the service delivery plan, all participants are provided with a standardized template. In supporting the person, consultation service providers will review whether the plan meets assessed needs outlined in the assessment and contains covered services. Within 10 business days, consultation service providers then submit the service delivery plan to the county, tribal human services agency, or MCO, who is the delegate of the SMA. The service delivery plan must then be approved by the county, tribal human services agency, or MCO within 30 calendar days.

Each county, tribal human services agency, or MCO utilizes Minnesota's Medicaid Management Information System (MMIS) and MnCHOICES database systems, which incorporate rules to ensure only services and supports authorized by the SMA are approved in the plan. All plans are subject to the approval of the SMA. An individual service delivery plan will not be approved by the SMA unless the individual meets all financial eligibility criteria and needs based service criteria.

The SMA conducts annual reviews, as defined in the QIS section of this document, of all consultation service providers who retain a copy of the completed and approved service delivery plans. The review of the service delivery plan is multifaceted. The state will review no less than 8 service delivery plans from each contracted and enrolled consultation service provider agency using the 8/30 methodology as outlined in the QIS section. While conducting a review of the service delivery plan, the SMA will evaluate whether service plans:

- meet assessed needs as outlined in the needs-based assessment;
- Have been updated annually;
- Document choice of services;
- Document choice of providers;
- Document choice of setting;
- Address worker training and development; and
- Include emergency back-up plans.

In addition to reviews completed for consultation services, the following oversight of counties, tribal human services agencies, and MCOs is conducted.

The SMA provides oversight of counties and tribal human services agencies through lead agency reviews. Lead agency reviews are continuous and ongoing, with approximately 20 lead agencies reviewed each year. During lead agency reviews a representative sample of approved service plans are audited and reviewed using the above mentioned 8/30 methodology where no less than 8 approved service plans will be reviewed for compliance at each of the selected counties and tribal human service agencies.

The SMA also provides oversight of MCOs by auditing and reviewing a representative sample of approved service plans, on an annual basis, where no less than 8 approved service plans will be reviewed for compliance at each of the MCOs.

In addition, the following measures, outlined in more detail in the quality assurance section of this plan, are in place to ensure ongoing SMA oversight of service plan development:

- Contract monitoring of consultation services providers;
- Desk audits to review service delivery plans;
- Care plan audits and quality review activities of MCOs;
- Review and analysis of participant satisfaction surveys;
- Ongoing oversight of the state MMIS system;
- Ongoing oversight of the states MnCHOICES system; and
- Review and analysis of participant appeals and fair hearing outcomes.

9. **Maintenance of Person-Centered Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency	☐	Operating agency	☐	Case manager
☒	Other (*specify):*	The service delivery plan is maintained by the county, tribal human services agency, or MCO for a minimum of three years.			

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Personal Care Assistance

Service Definition (Scope):

Personal care assistance provided by a personal care support worker includes assistance to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related procedures and tasks through hands-on assistance to accomplish the task or constant supervision/cueing to accomplish the task.

Personal care assistance may also include observation and redirection to the participant for episodes of behavior that need redirection (as identified in the service delivery plan).

ADLs include dressing, grooming, bathing, eating, transfers, mobility, positioning and toileting.

IADLs include activities related to living independently in the community. Covered services include providing assistance with:

- Completing household tasks necessary to support the participant with an assessed need including meal planning, preparation and cooking, shopping for food, clothing or other essential items;
- Doing Laundry and light housecleaning;
- managing medications;
- Assistance with managing finances
- Communicating needs and preferences during covered activities ;
- Arranging for participant supports
- Attending medical appointments;
- Traveling around and accompanying the person to participate in community activities; and
- Communicating by telephone or other devices.

Health-related procedures and tasks are procedures and tasks performed by a personal care support worker that can be delegated or assigned by a health care professional licensed under Minnesota state law.

Health-related procedures and tasks includes assistance with self-administered medications, interventions for seizure disorders, range-of-motion and passive exercise, clean tracheostomy suctioning and services to a participant who uses ventilator support, or other activities within the scope of personal care assistance that meet the definition of health-related procedures or tasks.

Personal care assistance may be delivered individually (1:1) or as shared care (1:2 or 1:3).

Participants determine whether or not they wish to use shared care. Participants then work with their service agency or FMS provider to enter into a voluntary written agreement to receive shared care. This is also built into their service delivery plan. An individual's personal care hours are not impacted by choosing shared care as an option but it may have implications for their budget, allowing them to stretch their service dollars further. This is then billed as shared care by either the service agency or the FMS, depending on the model.

The acquisition, maintenance and enhancement of skills necessary for the individual to accomplish ADLs, IADLs and health-related tasks is also included as personal care assistance.

Personal care assistance provided by a personal care support worker as described above includes activities that allow time for skills training through hands-on assistance, supervision and/or cueing to accomplish the ADL, IADL and health-related tasks. When an assessment shows that a person needs assistance to acquire, maintain and/or enhance the skills necessary to accomplish ADLs, IADLs, and health-related tasks, the person will receive this support concurrently (with hands-on assistance, or constant supervision and/or cueing) to accomplish the task. This will be done as described under the personal care assistance services description.

Assistance to acquire, maintain and/or enhance skills will be specifically tied to the assessment and service delivery plan. These are a means to maximize independence and integration in the community, preserve functioning and defer or eliminate the likelihood of future institutional placement. These services are limited to supports necessary for the participant to acquire, maintain or enhance skills to independently accomplish, to the extent possible, ADLs, IADLs, and health-related tasks as described under personal care assistance services.

Personal Care Support workers provide assistance under the following conditions:

- The need for skill training or maintenance activities if identified by the assessment process and it has been documented in the authorized service delivery plan;
- The activities provided are concurrent with the performance of ADLs, IADLs and health- related tasks as described above;
- The activities are for the sole benefit of the participant and are only provided to the participant receiving services;
- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence;
- The activities provided are consistent with the stated preferences and outcomes in the service delivery plan; and
- The support worker is competent to perform these services for participants

Personal care assistance services do not include:

- services provided by a participant's representative or paid legal guardian;
- Services that are used solely as a childcare or babysitting service;
- Services for adults that are used solely for supervision like adult companion or adult day service;
- Services that are the responsibility or in the daily rate of a residential or program license holder under the terms of a service agreement and administrative rules;
- Sterile procedures;
- administering injections into veins, muscles or skin;
- Homemaker services that are not an integral part of the assessed service;
- Home maintenance or chore services;
- Home care services, including hospice services if elected by the participant, covered by Medicare or any other insurance held by the participant;
- Services to other members of the participant's household;
- Services not specified as covered under medical assistance;
- Application of restraints or implementation of deprivation procedures; and
- Independently determining the medication dose or time for medications for the participant.

In the budget model, the participant is the employer of their own personal care support workers. The participant recruits, hires, trains and supervises their worker.

In the provider agency model, the participant selects an agency that serves as the support worker's employer. This means the agency recruits, hires (including workers selected by the participant, if the worker meets qualifications), trains, supervises and pays the personal care assistance worker.

Describe any limitations for the systems or mechanisms provided:
Personal care support workers are limited to providing 310 hours of care per calendar month, regardless of the number of participants being served or the number of agencies or participants employing the support worker.

- If a parent(s), stepparent(s), unpaid legal guardian(s) of a participant under age 18 or the participant's spouse works as a person's personal care support worker, they may not provide personal care assistance in excess of the following:
  - If multiple parents are support workers providing personal care assistance to their minor child or children, each parent may provide up to 40 hours of personal care assistance in any seven-day period regardless of the number of children served. The total number of hours of personal care assistance provided by all of the parents must not exceed 80 hours in a seven-day period regardless of the number of children served.
  - If only one parent is a support worker providing personal care assistance to the parent's minor child or children, the parent may provide up to 60 hours of personal care assistance in a seven-day period regardless of the number of children served.
  - If a participant's spouse is a support worker providing personal care assistance, the spouse may provide up to 60 hours of personal care assistance in a seven-day period.
  - For parents of minor children and spouses, the hour outlined above apply to the total amount of hours per family regardless of the:
    - Number of parents
    - Combination of parent(s) and spouse
    - Number of children who receive 1915(i) benefits.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☒	Medically needy *(specify limits):*
	The services under this 1915(i) benefit are limited to services not otherwise covered under the state plan, including EPSDT and must be consistent with SPA objectives of avoiding institutionalization.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*

Personal Care Support Workers	N/A	N/A	All support workers, regardless of delivery model must: • Complete the standardized certification training and pass the test named "Personal Care Assistance (PCA) and Community First Services and Supports (CFSS) Training and Test" • Pass a background study initiated by the provider agency/FMS provider, as required under Minnesota Statutes, Chapter 245C • Enroll with Minnesota Health Care Programs as a PCA/CFSS support worker • Be able to communicate effectively with the participant and the provider agency/FMS provider • Have the skills and ability to provide the services and supports according to the participant's service delivery plan and respond appropriately to the participant's needs The participant may establish additional support worker qualifications.
CFSS Agency Provider	N/A	N/A	An agency provider must meet the following qualifications: • Enrolled as a Medical Assistance/Minnesota Health Care Programs (MHCP) provider or enrolled in an MCO network • Meet all applicable provider standards and requirements • Comply with background study requirements under Minnesota Statutes, chapter 245C and maintain documentation of background study requests and results.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

Personal Care Support Worker	State Medicaid Agency	The SMA must check the Office of Inspector General (OIG) exclusion list at enrollment and then at least monthly thereafter.
CFSS Provider Agency	State Medicaid Agency	Every 3 years

Service Delivery Method. *(Check each that applies)*:

X	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Personal Emergency Response Systems (PERS)

Service Definition (Scope):

Personal emergency response systems (PERS) includes:

- Purchase of the PERS equipment, including necessary training or instruction on the use of the equipment;
- Installation (including set up and testing) and monitoring of the device; and
- Monthly fees associated with operation of device.

Personal emergency response systems does not cover:

- Equipment used to deliver Medical Assistance (MA) or other waiver services;
- Sensing and/or monitoring systems that do not require activation by the participant (see CBSM – Monitoring technology usage, https://www.dhs.state.mn.us/main/dhs16_180346, for policy about those systems);
- Supervision or monitoring of activities of daily living (ADLs) provided to meet the requirements of another service;
- Telehealth and biometric monitoring devices; and
- Video equipment

The following information must be documented in the participant's service delivery plan:

- The participant's need for a personal emergency response system;
- The type of personal emergency response equipment the participant will use
- How the personal emergency response equipment will meet the participant's assessed need; and
- Fees for equipment purchase, installation and monthly monitoring.

Reimbursement for personal emergency response systems to ensure continuity of services and supports is available for any of the following:

- Participants who live alone or who are alone for significant parts of the day;
- Participants who have no regular caregiver for extended periods of time and who would otherwise require extensive routine support and/or supervision; or
- Participants who have not identified/chosen to identify a person for their back-up support.

Whether a participant chooses the agency or budget model of service delivery, they retain full budget authority for purchase of PERS. The purchase must meet the criteria outlined above and fit within the individualized budget. The service agency or participant employer is responsible to ensure the

personal emergency response systems meet the criteria outlined. The State Medicaid Agency also has quality assurance measures in place that are outlined in other areas of this document.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☒ Medically needy *(specify limits):*

The services under this 1915(i) benefit are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Personal Emergency Response Systems	N/A	N/A	PERS vendors can be either: 1) Minnesota Health Care Programs (MHCP) enrolled vendors or providers enrolled in MCO network(s) that meet one of the following qualifications: • State medical equipment provider as defined in state statute • Pharmacy licensed by the Minnesota Board of Pharmacy • Medicare-certified home health agency The participant or the representative is responsible to verify provider qualifications under the budget model. The Department's provider enrollment unit or the counties, tribal human services agencies, and MCOs are responsible to verify

			provider qualifications under the agency model.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Personal Emergency Response Systems	State Medicaid Agency	Every 5 years

Service Delivery Method. *(Check each that applies)*:

X	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Individual Directed Goods and Services

Service Definition (Scope)*:*

Individual Directed Goods and Services are services, equipment or supplies not otherwise available through the Medicaid state plan that address an identified need in the service plan (including improving and maintaining the participant's opportunities for full membership in the community) and must:

- increase an individual's independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance;
- not be available through another source,
- be purchased from the participant-directed budget; and
- Not be Experimental or prohibited treatments are excluded

Individual Directed Goods and Services must be documented in the service plan.

Expenditures for goods and services must:

- Relate to a need identified in a participant's service delivery plan;
- Be priced at fair market value;
- Increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for the human assistance for the participant's assessed need; and
- Fit within the annual limit of the participant's approved service allocation or budget

Examples of covered goods and services include:

- Wheelchair ramps
- Smart phone applications relevant to assisting participants with ADL/IADL needs
- Specialized devices for dressing or grooming
- Microwave
- Laundry service
- Environmental modifications

Goods that are covered under the Medicaid Durable Medical Equipment benefit would not be covered by this benefit.

Whether a participant chooses the agency or budget model of service delivery, they retain full budget authority for the purchase of Individual Directed Goods and Services. The purchase must meet the criteria outlined above and fit within the individualized budget.

When a participant uses funds to purchase individual directed goods and services, the consultation services provider will review the service delivery plan with the person. In supporting the person, they will review whether the good or service meets an assessed need outlined in the needs assessment, is a covered service and fits within the individual's budget. The consultation service provider submits the plan to the county, tribal human services agencies, or MCO, the delegate of State Medicaid Agency for approval. The state Medicaid agency provides oversight via audits and reviews of a representative sample of approved service plans. All individual directed goods and services must be purchased through the FMS provider unless the provider of the good or services is an MHCP enrolled provider, in which case the provider can bill directly for the good or service.

When a participant is choosing to use individually directed goods and services the cost for the goods and services is covered using a portion of the allocated budget.

Describe any limitations for the systems or mechanisms provided:
Individual Directed Goods and services are limited to what is covered above. Individually directed goods and services must not exceed an individual's budget allowance.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☒ Medically needy *(specify limits):*

The services under this 1915(i) benefit are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Goods and Service Providers	N/A	N/A	Entities providing individual directed goods or services must bill though the Financial Management Services provider or enrolled MHCP. All individuals/vendors that provide individual directed goods and services must have: • The capability to perform the requested work

			• The ability to successfully communicate with the participant • All the necessary professional and/or commercial licenses required by federal, state and local laws and regulations, if applicable.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Goods and Service Providers	State Medicaid Agency	When goods or services are billed

Service Delivery Method. *(Check each that applies)*:

X	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Financial Management Services (FMS)

Service Definition (Scope)*:*

Financial Management Services is a service/function that assists the family or participant to:

(a) manage and direct the disbursement of funds contained in the participant-directed budget;

(b) facilitate the employment of staff by the family or participant, by performing as the participant's agent such employer responsibilities as processing payroll, withholding federal, state, and local tax and making tax payments to appropriate tax authorities; and,

(c) performing fiscal accounting and making expenditure reports to the participant or family and state authorities.

"Financial management services provider" means a qualified organization required for participants who use the budget model. An FMS is an enrolled provider that provides vendor fiscal/employer agent financial management services (FMS).

Participants who use the budget model must select a financial management services (FMS) provider.
The role of the FMS provider is to support the participant as they fulfill their responsibilities of being the employer of their personal care support workers. The FMS provider is responsible to:

- Collect and process timesheets of the participant's support workers
- Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
- Separately track budget funds and expenditures for each participant
- Track and report disbursements and balances of each participant's funds
- Process and pay invoices for services in the person-centered service delivery plan

- Provide individual, periodic reports of expenditures and the status of the approved service budget to the participant or their representative and SMA, as well as the consultation service provider and county, tribal human services agency, or MCO, as applicable
- Initiate background studies for support workers
- Help the participant obtain support workers' compensation insurance
- Educate the participant on how to employ support workers
- Ensure what the participant spends their funds on follows the rules of the program and the approved service delivery plan.

Participants who use the agency-provider model and choose to purchase individual directed goods and services with their service allocation must use an FMS provider to purchase the goods and services if the provider of the goods and services is not an enrolled MHCP provider.

Participants must not be limited in their choice of FMS provider. Participants are able to choose from any provider who is contracted and enrolled with the SMA as an FMS provider.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☒ Medically needy *(specify limits):*

The services under this 1915(i) benefit are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Financial Management Services	N/A	Federal Certification through readiness review	The SMA contracts with all FMS providers to provide FMS services. The SMA determines if FMS providers meet the qualifications through a Request for Proposal (RFP) process at a frequency determined by the SMA. All FMS providers shall: • Enter into a contract with the SMA for provision of FMS services • Enroll as a Minnesota HealthCare Programs (MHCP) provider and meet all applicable provider standards and requirements • Comply with background study requirements under Minnesota

			Statutes, Chapter 245C and maintain documentation of background study requests and results • Successfully complete a readiness review conducted by an individual or organization that meets the qualifications required by the state • Have knowledge of and compliance with Internal Revenue Service (IRS) requirements • Provide services statewide • Meet the requirements under a collective bargaining contract.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Financial Management Services	State Medicaid Agency	Every 5 Years

Service Delivery Method. *(Check each that applies)*:

X	Participant-directed	X	Provider managed

2. ☒ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

(a) For minors, parents, stepparents, and unpaid legal guardians may be paid to provide personal care. For adults, unpaid legal guardians may be paid to provide personal care.

(b) The specific state plan HCBS service is personal care.

(c) The determination about whether provision of personal care by a responsible relative or paid legal guardian is in the best interest of the participant is made through the comprehensive person-centered service planning process.

(d) When personal care is provided by a responsible relative or paid legal guardian, the county, tribal human service agency or MCO conducts a semi-annual in-person review with the participant of their plan. In addition, quarterly spending reports must be provided to the county, tribal human service agency, MCO, or consultation service provider, respectively.

(e) All provider requirements pertaining to service payment apply to legally responsible individuals that provide personal care, including use of electronic visit verification.

(f) The person-centered assessment accounts for age appropriate dependencies and natural supports. Only services that exceed those levels are authorized. Personal care services provided by relatives, legally responsible individuals, and unpaid legal guardians may only include extraordinary care that exceeds the range of activities that the caregiver would ordinarily perform for a person of the same age without a disability or chronic illness.

Parents, stepparents, unpaid legal guardians of a participants under age 18 or the participant's spouse works as a person's personal care support worker, may not provide 1915(i) personal care assistance in excess of the following:

- If multiple parents are support workers providing personal care assistance to their minor child or children, each parent may provide up to 40 hours of personal care assistance in any seven-day period regardless of the number of children served. The total number of hours of personal care assistance regardless of the number of children served.
- If only one parent is a support worker providing personal care assistance to the parent's minor child or children, the parent may provide up to 60 hours of personal care assistance in a seven-day period regardless of the number of children served.

- If a participant's spouse is a support worker providing personal care assistance, the spouse may provide up to 60 hours of personal care assistance in a seven-day period.
- For parents of minor children and spouses, the hour outlined above apply to the total amount of hours per family regardless of the:
  - Number of parents
  - Combination of parent(s) and spouse
  - Number of children who receive personal care assistance.

Paid legal guardians are not allowed to be the support worker, whether the participant is a minor or an adult.

Services must be provided within the assessed limits. For people who receive services under the budget model, the consultation services provider and FMS will work to ensure that services are provided within the scope of the service delivery plan.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

Election of Participant-Direction. (Select one):

☐	The state does not offer opportunity for participant-direction of State plan HCBS.
☒	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
☐	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

1. **Description of Participant-Direction.** *(Provide an overview of the opportunities for participant direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

The state of MN has long viewed personal care assistance as a mechanism for individuals to have choice and control in their care while remaining in their homes and communities. Participants are offered two choices for service delivery.

There are two service delivery models: the provider agency model and the budget model. In both models, the participant:

- Directs their own care
- Selects their worker, including their spouse or parent of a minor
- Writes their plan with assistance from the consultation services provider, as desired
- Has full budget authority and the option to purchases goods, services and personal emergency response systems
- Has access to a worker training and development budget to help personal care support workers expand their skills to support the participant's specific needs

Before choosing a model, participants choose a Consultation service provider who provides them with information about service models, rights and responsibilities (including appeal rights, choice in providers and budget information and policies). Each participant eligible for the benefit has the choice to self-direct all or part of their services, depending on the service model chosen. After benefit eligibility has been determined participants are presented with their budget. They are offered support from Consultation Services to determine how their choice in models, purchase of goods and services or personal emergency response systems would impact their budget, giving all participants full budget authority from the start. Those choosing the budget model serve as the employer of their workers and have full employer and budget authority.

The consultation service provider also provides the participant with the service delivery plan template and provides support to develop the plan as directed by the participant. Participants may use the consultation service for assistance while developing a person-centered service delivery plan and budget and for learning how to recruit, select, train, schedule, supervise, direct, evaluate and dismiss personal care support workers. They may also return to consultation services at any time for additional supports.

In both models, participants have access to worker training and development for their personal care support workers. Worker training and development is a function that pays for the training, observation, monitoring and coaching of personal care support workers. These activities help personal care support workers expand their skills to support the participant's specific needs. The need for worker training and development is identified in the development of the service delivery plan and further needs might be identified as new workers are hired, new needs for the person emerge or additional training needs for a worker are identified. Worker training and development has a minimum annual allocation credited to each participant who receives services, which is separate from the participant's service delivery budget. Participants can request additional funds for the participant's worker training and development as needed.

In the budget model, the participant is the employer of their own personal care support workers. The participant recruits hires trains and supervises their worker. The person selects a financial management services (FMS) provider to help the person comply with applicable employment related laws. Participants will use a financial management services provider for the billing and payment of services; for ensuring accountability of funds; for management of spending and to serve as a vendor/fiscal employer agent in order to maintain compliance with employer related duties, including federal and state labor and tax regulations.

Under the budget model, participants accept more responsibility and control over the services and supports described and budgeted within their person-centered service delivery plan. Participants may use their service budget to directly employ and pay qualified support workers and obtain other supports and individual directed goods and services as defined in the service package.

2. Limited Implementation of Participant-Direction. *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to state wideness requirements. Select one):*

☒	Participant direction is available in all geographic areas in which State plan HCBS are available.
☐	Participant-direction is available only to individuals who reside in the following geographic areasor political subdivisions of the state. Individuals who reside in these areas may elect self-directedservice delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affectedby this option)*:

3. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
Personal Care Assistance	☒	☒
Individual Directed Goods and Services	☐	☒
Personal Emergency Response Systems	☐	☒

4. Financial Management. (*Select one)* :

☐	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
☐	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.
☒	Financial Management is furnished as a Medicaid 1915(i) service

5. ☒ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and: Specifies the State plan HCBS that the individual will be responsible for directing; Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget; Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual; Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

The consultation services provider is responsible to help a person change models if they choose to do so. This includes educating the person on their newly chosen model and helping update their service delivery plan, if the participant wants assistance.

If the participant is a senior enrolled in managed care, the case manager or care coordinator is responsible to update the person's service agreement or authorization if they choose to switch service delivery models.

The SMA is responsible to update the person's service agreement when they switch models.

Involuntary change
If a person who used the budget model is in the Minnesota Restricted Recipient program the person must switch to the agency-provider model.

If the participant is not meeting the requirements of the budget model such as:

- Not performing the required participant-employer activities
- Participant is knowingly committing fraud, waste, or abuse of budget fund
- Participant is repeatedly breaking HCBS rules despite corrective counseling
- Participant relocates to a non-community setting where HCBS are not permitted

In the circumstances above the consultation service provider must attempt to re-educate the person before the recommendation to remove them from the budget model.

If the person is not succeeding as a participant employer (i.e., the budget model), the consultation services provider is responsible to:

- Recommend the county, tribal human services agency, or MCO or SMA disallow the person from using the budget model, if necessary
- Help the person switch models if the SMA or the county, tribal human services agency, or MCO removes them from the budget model

The SMA is responsible to:

- Review and decide on recommendations from the consultation services provider about the person's ability to continue to successfully participate in the budget model
- Update the person's service agreement when they switch service delivery models (whether voluntarily or involuntarily)

The participant may appeal the decision to remove a person from the budget model.

Termination of services

A provider, defined as a personal care provider agency, Consultation Service provider or an FMS, must provide written notice when it intends to terminate services with a participant at least 30 calendar days before the proposed service termination is to become effective, except in cases where:

1) The participant engages in conduct that significantly alters the terms of the service delivery plan with the agency-provider;
2) The participant or other persons at the setting where services are being provided engage in conduct that creates an imminent risk of harm to the personal care support worker or other agency-provider staff;
3) An emergency or a significant change in the participant's condition occurs within a 24-hour period that results in the participant's service needs exceeding the participant's identified needs in the current service delivery plan so that the agency-provider cannot safely meet the participant's needs.

When a participant initiates a request to terminate services with the agency-provider, the provider must give the participant a written acknowledgment of the participant's service termination request that includes the date the request was received by the agency-provider and the requested date of termination.

The -provider must participate in a coordinated transfer of the participant to a new -provider to ensure continuity of care.

The only circumstance under which a person would be unable to continue with self-direction in the above example is if they receive a service termination notice from a provider and they have exhausted all efforts to obtain the service from another provider. In the event that they have exhausted all options, the SMA or delegate would assist the person to review other service options for meeting their needs. A termination of services from a service provider would not result in their benefit eligibility for HCBS being terminated.

Voluntary change

A participant can elect to switch service-delivery models (agency-provider model or budget model) at any time, unless they are not allowed to use the budget model (i.e., the person is on the Minnesota Restricted Recipient Program [MRRP]). The Minnesota Restricted Recipient Program is authorized by Federal regulation and was developed to improve the safety and quality of care, and to reduce the costs for Minnesota Health Care Program (MHCP) recipients who have misused or abused MHCP services.

When a person is both eligible to and considers switching models, they are responsible to:

- Identify if the service delivery model they are using is working for them
- Seek support from the provider agency or consultation services provider on their options, if necessary
- Notify their provider agency or consultation services provider if they wish to switch service delivery models
- Update their service delivery plan when they switch service delivery models

8. Opportunities for Participant-Direction

a. Participant–Employer Authority *(individual can select, manage, and dismiss State plan HCBS providers). (Select one):*

☐	The state does not offer opportunity for participant-employer authority.
☒	Participants may elect participant-employer Authority *(Check each that applies):*
	☐ **Participant/Co-Employer**. The participant (or the participant's representative) functions asthe co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☒ **Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll andother employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority *(individual directs a budget that does not result in payment for medical assistance to the individual). (Select one):*

☐	The state does not offer opportunity for participants to direct a budget.
☒	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	A service budget amount is based on an objective assessment of the participant's personal care needs as defined under Minnesota Statute and in compliance with 42 CFR 441.560. The assessment must be conducted by an assessor according to the criteria established in Minnesota Statute. A statistical model is applied to arrive at a total dollar and service amount. Once the total benefit amount is determined, the county, tribal human services agency, or MCO develops/tailors a detailed spending plan that meets the person preferences, as established in the service plan. After the assessment is completed, the assessor will provide the participant, by mail or in person, with a written summary outlining the needs for care and options for services and supports, including the total dollar amount for services. The participant works with the consultation services provider to understand how they will use funds. If the participant is on a waiver or a senior enrolled in managed care, the participant would work with the case manager or care coordinator to finalize the service delivery plan. All plans are subject to the approval of the county, tribal human services agency, or MCO. The state Medicaid agency provides oversight through audits of a representative sample of approved service plans. Participants may use their service budget to: • Directly employ and pay qualified personal care support workers • Purchase covered individual directed goods and services • Pay for the selected financial management services • Purchase personal emergency response systems

A person's budget is recalculated annually at reassessment. The budget also may be recalculated at any time during the year if the person has a change in need.

Approval
Service delivery plans must be reviewed by the consultation services provider and approved by the county, tribal human services agency, or MCO, the delegate of the State Medicaid Agency. A case manager or care coordinator must approve the plan for a waiver or alternative care program participant or for a senior who is enrolled in managed care. Consultation services and worker training/development are authorized on a per diem basis and do not count against a participant's service budget. The state Medicaid agency provides oversight through audits of a representative sample of approved service plans.

Participants are authorized for an initial six sessions of consultation services annually. The six sessions apply for each eligible participant, including when the participant's authorization is for less than 12 months. The participant, along with the consultation service provider, can request additional sessions. Additional sessions are approved by the SMA as requested.

A separate budget is available to people who employ their own workers (i.e., CFSS agency or person/representative on budget model). This is used to pay for training, observation, monitoring and coaching of workers. These activities help workers expand their skills to support the participant's specific needs. This has been outlined as an Administrative Activity.

Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

The consultation service provider works with the participant to develop a person-centered service delivery plan that recognizes risk factors and develops measures/strategies to mitigate them. Risk factors include premature depletion and underutilization of the assessed budget.

Participants who choose to use the budget model will need a financial management service (FMS) provider to assist with managing their budget. The FMS will:

- Review the risk mitigation plan and track expenditures accordingly
- Bill and make payments for expenditures
- Maintain records and provide participants with a monthly written summary of the spending for services and supports that were billed against the spending budget
- Work with the participant and the consultation services provider to monitor and mitigate risk

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c) document choice of services and providers.
2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
3. Providers meet required qualifications.
4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
5. The SMA retains authority and responsibility for program operations and oversight.
6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Table 1a-i

Requirement	***Service plans address assessed need of 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 1a-i Percent of service delivery plans that document services which address participant's ADL/IADL domains of assessed need. • Numerator: Number of participant plans that document services which address ADL and IADL domains of assessed need. • Denominator: Number of service delivery plans.
Discovery Activity *(Source of Data & sample size)*	The SMA will review a representative sample, as specified below, of 1915(i) benefit service delivery plans and determine if participant's assessed ADL/IADL needs have been addressed. Data source: Desk Audit, MMIS MnCHOICES data and participant plans submitted by consultation services provider. Sample size: *: Total number of all Consultation Service Provider files reviewed using 8/30 Methodology.*
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze service-plan audit data. • Work with consultation services providers to achieve remediation of substandard performance within 60 days. Remediation will entail submission of a remediation plan within 30 days. • Review and approve all corrective action plans and will continuously monitor providers' performance until the issue(s) are resolved. • Address a pattern of substandard performance through the provision of technical assistance and, where needed, modification to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 1a-ii

Requirement	***Service plans address assessed need of 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 1a-ii Percent of participants who reported that their support worker assisted them in meeting their service goals. • Numerator: Number of participants who reported satisfaction with their support worker assisting them in meeting their goals. • Denominator: Number of survey respondents who received services.
Discovery Activity *(Source of Data & sample size)*	The SMA directs collection of a participant 1915(i) benefit satisfaction data annually through a survey tool administered by consultation services providers. Data source: Annual participant survey Sample size: 1915(i) benefit participants receiving services/supports for at least three months under their current service plan.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze the 1915(i) benefit participant satisfaction data • Conduct root-cause analysis, investigating situations where participants reported that their support worker did not adequately assist them in meeting their service goals. • Follow up with the consultation services provider to assure that identified programmatic shortfalls have been/are being addressed • Address a pattern of substandard performance through the provision of technical assistance and, where it persists, modification to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 1b

Requirement	***Service plans are updated annually***

Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 1b Percent of participant's service delivery plans that are updated annually. • Numerator: Number of participant's whose most recent service delivery plan has been updated within a 12-month period. • Denominator: Number of participants who have a service delivery plan.
Discovery Activity *(Source of Data & sample size)*	The SMA will review a representative sample, as specified below, of participant's 1915(i) benefit service delivery plans to determine if they have been updated within a 12-month period Data source: Desk audit, MMIS MnCHOICES data and participant plans submitted by consultation services provider. Sample size: *Total number of all Consultation Service Provider files reviewed using 8/30 Methodology.*
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze service plan audit data. • Work with consultation services providers to achieve remediation of substandard performance within 60 days. Remediation will entail submission of a remediation plan within 30 days. • Review and approve all corrective action plans and will continuously monitor providers' performance until the issue is resolved. • Address a pattern of substandard performance through the provision of technical assistance and, where needed, modification to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 1c-i

Requirement	***Service plan documents choice of services and provider***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 1c-i Percent of service delivery plans that document participant choice of both services and providers. • Numerator: Number of service delivery plans that document participant choice of both services and providers. • Denominator: Number of service delivery plans.
Discovery Activity *(Source of Data & sample size)*	The SMA will review a representative sample, as specified below, of 1915(i) benefit service delivery plans to determine which ones documented participant choice of both services and providers. Data source: Desk Audit, MMIS MnCHOICES data and participant plans submitted by consultation services provider. Sample size: Total number of all Consultation Service Provider files reviewed using 8/30 Methodology.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze service plan audit data. • Work with consultation services providers to achieve remediation of substandard performance within 60 days. Remediation will entail submission of a remediation plan within 30 days. • Review and approve all corrective action plans and will continuously monitor providers' performance until the issue is resolved. • Address a pattern of substandard performance through the provision of technical assistance and, where needed, modification to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 1c-ii

Requirement	***Service plan documents choice of services and provider***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 1c-ii Percent of participants who reported that their consultation services provider informed them adequately of the program's person-centered practices and their service/protection related rights. • Numerator: Number of participants who reported satisfaction with their consultation services provider informing them adequately of the program's person-centered practices and their service/protection related rights. • Denominator: Number of survey respondents who received services.
Discovery Activity *(Source of Data & sample size)*	The SMA directs collection of a participant 1915(i) benefit satisfaction data annually through a survey tool administered by consultation services providers. Data source: Annual participant survey Sample size: 1915(i) benefit participants receiving services/supports for at least three months under their current service plan.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze the 1915(i) benefit participant satisfaction data • Conduct root-cause analysis, investigating situations where participants reported that their consultation services provider did not adequately inform them of the program's person-centered practices and their service/protection related rights. • Follow up with the consultation services provider to assure that identified programmatic shortfalls have been/are being addressed • Address a pattern of substandard performance through the provision of technical assistance and, where it persists, modification to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 1c-iii

Requirement	***Service plan documents choice of services and provider***
Discovery	

Discovery Evidence *(Performance Measure)*	Performance Measure 1c-iii Percent of participants who reported that their support worker adequately safeguarded their service/protection related rights. • Numerator: Number of participants who reported satisfaction with their support worker adequately safeguarding their service/protection related rights. • Denominator: Number of survey respondents who provided a response during the review period.
Discovery Activity *(Source of Data & sample size)*	The SMA directs collection of a participant 1915(i) benefit satisfaction data annually through a survey tool administered by consultation services providers. Data source: Annual participant survey Sample size: 1915(i) benefit participants receiving services/supports for at least three months under their current service plan.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze the 1915(i) benefit participant satisfaction data • Conduct root-cause analysis, investigating situations where participants reported that their 1915(i) benefit support worker did not adequately safeguard their service/protection related rights. • Follow up with the consultation services provider to assure that identified programmatic shortfalls have been/are being addressed • Address a pattern of substandard performance through the provision of technical assistance and, where it persists, modification to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 2a

Requirement	***Eligibility requirements: An evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future***
Discovery	

Discovery Evidence *(Performance Measure)*	Performance Measure 2a Percent of applicants who received a comprehensive assessment that included a determination of their medical needs. • Numerator: Number of applicants who received a functional assessment that included a determination of medical need. • Denominator: Number of applicants who applied during the benefit year.
Discovery Activity *(Source of Data & sample size)*	Upon request, all people in Minnesota are entitled to request and complete a functional assessment. They will be assessed for the needs they have at the time of assessment. The SMA reviews MMIS data to determine whether all 1915(i) benefit applicants have received an assessment that included a determination of their medical needs. Data Source: MMIS Sample Size: All 1915(i)benefit applicants.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA is responsible to assure that every 1915(i)benefit applicant received an equitable, person-centered functional assessment that included a determination of medical need. Where this did not occur, the SMA will ensure remediation within 30 days.
Frequency *(of Analysis and Aggregation)*	Annual

Table 2b

Requirement	***Eligibility requirements: The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 2b Percent of Participants/Applicants whose 1915(i) eligibility was determined by using the functional assessment. • Numerator: Number of Participants/Applicants whose 1915(i) eligibility was determined by using the functional assessment. • Denominator: Number of Participants/Applicants.
Discovery Activity *(Source of Data & sample size)*	The SMA monitors the administration of functional assessments. Data source: MMIS Sample size: All 1915(i) benefit Participants/Applicants.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MMIS edits direct 1915(i) benefit service/support eligibility in alignment with program requirements. For an increasing number of participants/applicants MnCHOICES drives the assessment via a series of rules-driven screens that the assessor completes in sequence. MnCHOICES determines 1915(i) benefit eligibility based on assessor responses and CFSS benefit requirements. The MnCHOICES printout directs the entry of determination data into MMIS. The SMA appeals process preserves the ability of those receiving assessments to challenge adherence to the processes/application of the instruments in making determinations. Appeals judges direct remediation of due appeals. 1915(i) benefit staff monitor trends in appeals that suggest program policies are not being properly implemented or need refining. The SMA may address the situation with clarifying technical assistance or policy refinements and other system improvements.
Frequency *(of Analysis and Aggregation)*	Annual

Table 2c

Requirement	***Eligibility requirements: The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 2c • Percent of participants who were reevaluated for 1915(i) benefit eligibility annually. • Numerator: Number of participants who were reevaluated for 1915(i) benefit eligibility within a 12-month period. • Denominator: Number of participants due for reevaluation of 1915(i) benefit eligibility.
Discovery Activity *(Source of Data & sample size)*	The SMA monitors the frequency of the administration of functional assessments. Data source: Medicaid Management Information System (MMIS) Sample size: All 1915(i) benefit participants due for reevaluation of 1915(i) benefit eligibility.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA MMIS database: • Prevents the payment of 1915(i) benefit services where a recipient has not received an assessment within the previous year. • Monitors claims on a continuous basis to confirm MMIS system edit functionality. • Generates a list to counties, tribal human services agencies, and MCOs. of all participants that need a reassessment within the next 60 days. • Generates a letter to providers telling them when the service agreement for a participant they are working with ends. • Generates a letter to the participant in advance of services ending that reminds them they will need a new assessment to continue services. The Operations and Data Integrity office works with the 1915(i) benefit policy area to remediate issues in the system as they are identified.
Frequency *(of Analysis and Aggregation)*	Annual

Table 3a-i

Requirement	***Providers meet required qualifications***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 3a-i Percent completion of support worker training directed by the support worker training and development plan for agency model participants. • Numerator: Number of agency model participants for whom support worker training was completed as directed by the support worker training and development plan for agency model participants. • Denominator: Number of agency model participants for whom support worker training was due to be completed.
Discovery Activity *(Source of Data & sample size)*	The SMA requires 1915(i) benefit agencies to submit annual reports on the person-centered training activity of 1915(i) benefit support workers serving agency model participants. Data source: Annual 1915(i) benefit agency provider reports Sample size: 1915(i) benefit agency model participants with current service plans completed before or within the third quarter of the review year
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze support worker training reports received from agency 1915(i) benefit agencies. Where it identifies that a support worker did not complete training as required in the training and development plan, it will review the agency's plan to assure that the support worker receives the training necessary to meet the participant's service needs. • Work with 1915(i) benefit agency providers to assure that the necessary support worker training occurs. • Work with consultation service providers to make any adjustments needed to • the service delivery plan, including the support worker's training and development plan.

	• Address a pattern of substandard 1915(i) benefit agency performance through the provision of technical assistance and, where needed, reassessment of the 1915(i) benefit agency's enrollment status.
Frequency *(of Analysis and Aggregation)*	Annual

Table 3a-ii

Requirement	***Providers meet required qualifications***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 3a-ii Percent completion of support worker training directed by the support worker training and development plan for budget model participants. • Numerator: Number of budget model participants for whom support worker training was completed as directed by the support worker training and development plan. • Denominator: Number of budget model participants for whom support worker training was due to be completed.
Discovery Activity *(Source of Data & sample size)*	The SMA requires consultation services providers to submit annual reports on the person-centered training activity of 1915(i) benefit support workers serving budget model participants. Data source: Annual 1915(i) benefit consultation services provider reports Sample size: 1915(i) benefit budget model participants current service plans completed before or within the third quarter of the review year
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze support worker training reports received from consultation services providers. Where it identifies a potential support worker competency issue, it will review the participant's service plan. • Work with consultation services providers to assure that the necessary support worker training occurs and accurate documentation is maintained.

	• Address a pattern of substandard consultation services provider performance through the provision of technical assistance and, where needed, modification reassessment to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 3a-iii

Requirement	***Providers meet required qualifications***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 3a-iii Percent of budget model participants served by support workers determined at performance review to adequately perform job functions. • Numerator: Number of budget model participants served by support workers determined to adequately perform job functions. • Denominator: Number of budget model participants where support worker performance was evaluated.
Discovery Activity *(Source of Data & sample size)*	The SMA directs collection of a participant 1915(i) benefit satisfaction data annually through a survey tool administered by consultation services providers. Data source: Annual participant survey Sample size: 1915(i) benefit budget model participants who receive services/supports for at least three months under their current service plan
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze the 1915(i) benefit participant satisfaction data. • Conduct root-cause analysis, investigating situations where participants reported that they were dissatisfied with support worker performance. • Follow up with the consultation services provider to assure that identified programmatic shortfalls have been/are being addressed. • Address a pattern of substandard performance through the provision of technical assistance and, where it persists, modification to the provider's contract.

Frequency *(of Analysis and Aggregation)*	Annual

Table 4a-i

Requirement	***Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 4a-i Percent of claims paid to providers who have attested to compliance with HCBS settings regulations. • Numerator: Number of claims paid to providers who have attested to compliance with HCBS settings regulations. • Denominator: Total number of claims paid to providers.
Discovery Activity *(Source of Data & sample size)*	As part of the provider enrollment process, the SMA reviews all 1915(i) benefit provider applications for compliance with home and community-based settings regulations which includes attestation and a pre-enrollment site visit. The SMA also maintains a series of MMIS system edits to ensure that payment is made only to qualified, HCBS settings-compliant providers authorized to provide the service(s) for which they have billed. It routinely monitors the functionality of its 1915(i) benefit qualified provider edits through comparative analysis with claims data. This assesses whether the 1915(i) benefit provider was fully qualified to deliver services on the claimed date of service delivery. Using claims data, the SMA is able to track the initial and continuous compliance of providers to deliver 1915(i) benefit services. Data source: MMIS claims and MHCP provider enrollment subsystems Sample size: Total claims paid to 1915(i) benefit providers during the review period.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA: • Verifies that providers initially and continually meet required certification and other service standards, including compliance with HCBS regulations, before being approved to deliver 1915(i) benefit services. Providers that do not meet and maintain required standards will not be authorized or paid to provide 1915(i) benefit services. • Routinely reviews claims reports to assure the ongoing functionality of system edits that prevent non-qualified providers from being approved to deliver and receive payment for 1915(i) benefit services.

Table 4a-ii

Requirement	***Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 4a-ii Percent of service delivery plans that document participant choice of provider and HCBS/institutional setting. • Numerator: Number of service delivery plans that document participant choice of provider and HCBS/institutional setting. • Denominator: Number of service delivery plans.
Discovery Activity *(Source of Data & sample size)*	The SMA will review a representative sample, as specified below, of 1915(i) benefit service delivery plans. This includes assessment of the participant's choice of provider and choice of HCBS or institutional setting. Data source: Desk Audit, MMIS MnCHOICES data, and participant plans submitted by consultation service providers. Sample size: *Total number of all Consultation Service Provider files reviewed using 8/30 Methodology.*
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; requiredtimeframes for remediation)*	The SMA will: • Aggregate and analyze service-plan audit data. • Work with consultation services providers to achieve remediation of substandard performance within 60 days. Remediation will entail submission of a remediation plan within 30 days. • Review and approve all corrective action plans and will continuously monitor providers' performance until the issue(s) is resolved. • Address a pattern of substandard performance through the provision of technical assistance and, where needed, modification to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 4a-iii

Requirement	***Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 4a-iii Percent of applicants who received a comprehensive assessment, including a determination that the individual's place of residence is compliant with HCBS settings regulations. • Numerator: Number of applicants who received a comprehensive assessment, including a determination that the individual's place of residence is compliant with HCBS settings regulations. • Denominator: Number of applicants who applied during the benefit year.
Discovery Activity *(Source of Data & sample size)*	Upon request, all people in Minnesota are entitled to request and complete a functional assessment. In order to qualify for 1915(i) benefit services the assessment must determine that the individual's residence is compliant with HCBS settings regulations. The SMA reviews MMIS data to determine whether all 1915(i) benefit applicants have received an assessment that included a determination of eligibility for 1915(i) benefit services based on compliance with HCBS settings regulations. Data source: MMIS Sample size: All 1915(i) benefit applicants.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Minnesota Medicaid Management System (MMIS) edits direct 1915(i) benefit service/support eligibility in alignment with program requirements, including settings standards. For an increasing number of participants/applicants MnCHOICES drives the assessment via a series of rules-driven screens that the assessor completes in sequence. MnCHOICES determines 1915(i) benefit eligibility based on assessor responses and 1915(i) benefit requirements. The SMA is responsible to assure that every 1915(i) benefit applicant received an equitable, person-centered functional assessment that included a determination of compliance with HCBS settings regulations. Where this did not occur, the SMA will ensure remediation within 30 days.
Frequency *(of Analysis and Aggregation)*	Annual

Table 5a-i

Requirement	***The SMA retains authority and responsibility for program operations and oversight.***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 5a-i Percent of all consultation services provider contract deficiencies resolved during the contract review cycle. • Numerator: Number of consultation services provider contract deficiencies resolved during the contract review cycle. • Denominator: Number of consultation services provider contract deficiencies issued during the contract review cycle.
Discovery Activity *(Source of Data & sample size)*	The SMA will assess consultation services provider performance across review of participant service delivery plan content. Review includes documentation of services to meet assessed need, updates to the service delivery plan at least annually, participant choice of both services and providers and the inclusion of an emergency back-up plan. Where the SMA identifies inadequate performance we will work with consultation services providers to achieve remediation of substandard performance within 60 days. Remediation entails submission of a formal assurance (signed by the lead professional staff) of correction of all file deficiencies within 30 days. The SMA will provide technical assistance as needed and continuously monitor provider's performance until the issue(s) are resolved. The SMA will address a pattern of sustained substandard performance through modification to the provider's contract and/or disenrollment. Data source: Consultation services provider contract performance database. Sample: All consultation services provider deficiencies identified during the contract review cycle.
Monitoring Responsibilities *(Agency or entity thatconducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze service-plan audit data. • Work with consultation services providers to achieve remediation of substandard performance within 60 days. Remediation will entail submission of a remediation plan within 30 days. • Review and approve all corrective action plans and will continuously monitor providers' performance until the issue(s) is resolved. • Address a pattern of substandard performance through the provision of technical assistance and, where needed, modification to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 5a-ii

Requirement	***The SMA retains authority and responsibility for program operations and oversight.***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 5a-ii Percent of all required data, reports, metrics requested by the SMA that was completed accurately and timely by 1915(i) providers including Consultation Service, Financial Management Services, 1915(i) provider agencies. • Numerator: Number of providers submitting required information accurately and timely • Denominator: Total number of providers
Discovery Activity *(Source of Data & sample size)*	The SMA will continually assess provider performance across provider enrollment and compliance, contract review and ongoing audits. Where the SMA identifies inadequate performance we will work with providers to achieve remediation of substandard performance within 60 days. This time period will be reduced where indicated by policy or state statute. Data source: MMIS, MnCHOICES, Desk audit, provider enrollment database. Sample: All provider deficiencies identified
Monitoring Responsibilities *(Agency or entity thatconducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze audit data. • Work with providers to achieve remediation of substandard performance within 60 days. Remediation will entail submission of a remediation plan within 30 days. • Review and approve all corrective action plans and will continuously monitor providers' performance until the issue(s) is resolved. • Address a pattern of substandard performance through the provision of technical assistance and, where needed, modification to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 6a

Requirement	***The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 6a For participants receiving services through the Fee-for-Service model, percent of service claims paid where there was a corresponding prior authorization. • Numerator: For participants receiving services through the Fee-for-Service model, number of Service claims paid where there was a corresponding authorization in the calendar year. • Denominator: Total number of Fee-for-Service claims paid for participants.
Discovery Activity *(Source of Data & sample size)*	The SMA reviews all 1915(i) benefit service claims. Data source: MMIS Sample size: All 1915(i) benefit service claims paid using the Fee-for-Service model during the review period.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects,*	Claims without prior authorization are rejected. Many potential claims and coding problems are averted through interactive MMIS edits, including edits related to

analyzes, and aggregates remediation activities; required timeframes for remediation)	eligibility, screening data, authorization criteria and other provider status. Payment of 1915(i) benefit claims is made only after alignment of a number of records in MMIS, including all of the following: • Service was authorized in the service agreement the county, tribal human services agencies, or MCO entered into MMIS. (The service agreement includes the rate, time span, units, type of service, and provider for each service to be provided) • A screening document identifies the enrollee to whom services were delivered as 1915(i) benefit eligible • The enrollee for whom services were delivered was eligible for Medical Assistance • An active provider number on the claim matches the provider number on the service authorization and corresponds to a provider that is enrolled to deliver this service (category of service) • Services are claimed within service authorization parameters and limits If a service agreement is unable to be entered, the county, tribal human services agencies, or MCO follows up with the provider, participant or financial worker to remedy the issue. The Operations and Data Integrity office works with the 1915(i) benefit policy area to remediate issues in the system as they are identified.
Frequency *(of Analysis and Aggregation)*	Annually

Table 7a-i

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance measure 7a-i Percent of both new and existing Support Workers that completed training on (1) child protection, (2) maltreatment of vulnerable adults, and (3) responsibilities as mandated reporters. • Numerator: Number of Support Workers that completed training on (1) child protection, (2) maltreatment of vulnerable adults, and (3) responsibilities as mandated reporters. • Denominator: Total number of Supports Workers approved to deliver services.
Discovery Activity *(Source of Data & sample size)*	The SMA reviews the training received by support workers to report suspected maltreatment. Data source: Medicaid Management Information System (MMIS)

	Sample size: All 1915(i) benefit Program Supports Workers approved to deliver 1915(i) benefit services.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities;required timeframes for remediation)*	Minnesota has established processes for reporting abuse, neglect and exploitation of vulnerable adults and minors. The SMA requires all providers that deliver direct care services to 1915(i) benefit participants to take complete training on how to prevent, recognize and report suspected maltreatment. The SMA keeps a cataloged list of each individual worker complete with their certification number that outlines whether they have completed the training. This information stays in their provider file. Support workers are not able to be enrolled to provide services until this training is complete. The state's requirement is that reports of suspected maltreatment of an adult who is vulnerable are entered immediately into the state's Social Service Information System (SSIS) and referred to Lead Investigative Agencies within the 2 business day statutory requirement. The MAARC system and operation is tightly managed with multiple quality assurance measures in place. This includes hourly service level analysis and monitoring. The MAARC reporting system complies with statute and uses the (SSIS) and Data Warehouse to ensure timely entry, receipt, and referral of reports. Issues impacting timelines of report referral are remediated immediately upon discovery with associated plans for prevention through coaching, training or system enhancements.
Frequency *(of Analysis and Aggregation)*	Annual

Table 7a-ii

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***

Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 7a-ii Percent of reports involving participants that were submitted to the Minnesota Adult Abuse Reporting Center (MAARC) and then referred to a Lead Investigative Agency (LIA) within two working days. • Numerator: Number of reports involving participants that were submitted to the MAARC and then referred to LIA within two working days. • Denominator: Number of reports involving participants that were submitted to MAARC and then referred to LIA.
Discovery Activity *(Source of Data & sample size)*	The SMA monitors the timely response to reports of alleged maltreatment involving vulnerable adults that receive 1915(i) benefit services and supports. Data source: Social Service Information System (SSIS) Sample size: All reports of alleged maltreatment involving adults that received 1915(i) benefit services and supports during the review period.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA operates the Minnesota Adult Abuse Reporting Center (MAARC). MAARC staff screen reports for immediate risks, referring all cases involving an identified safety issue to county and tribal human services agencies. MAARC immediately forwards reports containing information involving an alleged crime to law enforcement. Within two working days, the MAARC refers all reports to lead investigative agency (LIA) responsible for review and investigation of such reports. It has performance measures and a system of quality review for the MAARC. There are no required timeframes for remediation of Minnesota Adult Abuse Reporting (MAARC) performance issues. The state's requirement is that reports of suspected maltreatment of an adult who is vulnerable are entered immediately into the state's Social Service Information System (SSIS) and referred to Lead Investigative Agencies within the 2 business day statutory requirement. The MAARC system and operation is tightly managed with multiple quality assurance measures in place. This includes hourly service level analysis and monitoring. The MAARC reporting system complies with statute and uses the (SSIS) and Data Warehouse to ensure timely entry, receipt, and referral of reports. Issues impacting timelines of report referral are remediated immediately upon discovery with associated plans for prevention through coaching, training or system enhancements.

Frequency *(of Analysis and Aggregation)*	Annually

Table 7a-iii

Requirement	***The state identifies, addresses, and seeks to prevent incidentsof abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 7a-iii Percent of service delivery plans that document participant received information on how to report abuse, neglect, and exploitation. • Numerator: Number of service delivery plans that document participant received information on how to report abuse, neglect, and exploitation. • Denominator: Number of service delivery plans submitted.
Discovery Activity *(Source of Data & sample size)*	The SMA will review a representative sample, as specified below, of 1915(i) benefit service delivery plans. Data source: Desk Audit, MnCHOICES data Sample size: *Total number of all Consultation Service Provider files reviewed using 8/30 Methodology.*
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; requiredtimeframes for remediation)*	The SMA will: • Aggregate and analyze service-plan audit data. • Work with consultation services providers to achieve remediation of substandard performance within 60 days. Remediation will entail submission of a remediation plan within 30 days. • Review and approve all corrective action plans and will continuously monitor providers' performance until the issue(s) is resolved. • Address a pattern of substandard performance through the provision of technical assistance and, where needed, modification to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 7a-iv

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance measure 7a-iv Percent of new providers that conduct criminal background checks on new prospective employees • Numerator: Number provider agencies applying for enrollment that performed required background studies • Denominator: Total number of agencies applying for enrollment
Discovery Activity *(Source of Data & sample size)*	SMA reviews the required application materials with every enrollment application Data source: Provider enrollment screening process Sample size: All 1915(i) providers (including 1915(i) agencies, Consultation Service providers and FMS) enrollment
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities;required timeframes for remediation)*	Applicants who do not have all required background study documentation submitted with enrollment application will not be approved for enrollment. The SMA provides the prospective provider with a request for additional information and given 30 days to respond. If the required background study information is not provided they will not continue to be screened for potential enrollment until the required information is provided.
Frequency *(of Analysis and Aggregation)*	Ongoing

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

The SMA will routinely analyze 1915(i) benefit process data and the response data amassed through annual 1915(i) benefit participant surveys. 1915(i) benefit participant satisfaction data. Complimentary analysis measures the extent to which key functions assigned to program providers occurred and the extent to which they were effective in maximizing participant independence, safeguarding participant health and safety, and assisting the participant in meeting their goals.

Performance trends will identify the need for further analysis, prioritizing improvement initiatives based on analytic findings and the opportunity for targeted intervention.

2. Roles and Responsibilities

A team of SMA program and policy staff will review and analyze program operations, participant survey, performance measures, and remediation data. The team will identify opportunities for system improvements (e.g., improved training, provider standards, etc.) Policy staff will review emerging issues with the 1915(i) benefit's Implementation Council that comprises participant, provider and community representatives.

3. Frequency

The SMA will review and analyze program process and outcome data on an ongoing basis. Policy staff will meet quarterly with the 1915(i) benefit's Implementation Council to review and assess findings, contemplating program improvement initiatives where applicable.

4. Method for Evaluating Effectiveness of System Changes

When a performance finding indicates the need for intervention beyond standard remediation processes, the SMA will a rigorously identify and develop targeted improvement initiatives. The SMA will routinely monitor improvement initiatives and conduct targeted/evaluative assessment to gauge theeffectiveness of the interventions it implements.

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☒	HCBS Personal Care

HCBS Personal Care Assistance payment under the agency-provider model with service unit allocation is the lower of the submitted charge, or the state agency established rate, up to the number of units authorized in the participant's approved service allocation:

Personal Care 1:1 unit $5.95

Personal Care 1:2 unit $4.47

Personal Care 1:3 unit $3.92

NOTE: One unit is equal to 15 minutes.

Participants receiving services under the agency-provider model who then transfer to the budget model, will have any remaining service units converted to a service budget as described above.

Shared care:

For two participants sharing services, payment is one and one-half times the payment for serving one participant. For three participants sharing services, payment must not exceed two times the payment for serving one participant. This paragraph applies only to situations in which all participants were present and received shared services on the date for which the service is billed. Rate formulas are as follows:

For 1:2 shared care the formula is: $5.95 multiplied by 1.5 = $8.93 divided by 2 = 4.47

This formula enables us to not exceed the maximum rate of 1.5 times the payment rate for serving one participant.

For 1:3 shared care the formula is: $5.95 multiplied by 1.98 = 11.79 divided by 3 = 3.92

This formula enables us to not exceed the maximum rate of two times the payment rate for serving one participant.

Direct staffing wage costs were the main driver of rates. The rate methodology consisted of:

• A base wage index was established using Minnesota-specific wages taken from job descriptions and standard occupational classification codes from the BLS Occupational Handbook.

• A competitive workforce factor multiplier was applied to the direct staffing wage to address the difference in average wages for direct care staff and other occupations with similar education, training, and experience requirements, as identified by the BLS Occupational Handbook.

• The average wages were adjusted to differentiate between shared and individual staffing.

• Shared staffing was taken into account, when staff are available to provide services to more than 1 person and individual staffing, when direct care staff are available to solely provide support as a 1-to-1 interaction with a specific individual.

• These wage expenses were multiplied by factors for relief staffing, ancillary staff needs, employee-related taxes and benefits, and client programming.

Budget Model:

Under the budget model, an amount equal to the participant's authorized service units multiplied by the amount listed above for a 1:1 unit (@ $5.95) is authorized for use by the participant.

Shared care: For 1:2 and 1:3 shared care under the budget model, services are billed in the shared care formula outlined above.

An enhanced rate of 107.5 percent of the rate paid for CFSS must be paid for services provided to persons who qualify for ten or more hours of CFSS per day when provided by a support worker who meets the training requirements.

☐	HCBS Adult Day Health
☐	HCBS Habilitation
☐	HCBS Respite Care

For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
X	Other Services (specify below)
	Personal Emergency Response Systems (PERS): Personal emergency response systems include three parts. Each part has its own limit per service agreement year: • Purchase of the PERS equipment, including necessary training or instruction on use of the equipment ($1,500 maximum) • Installation, setup and testing of the PERS equipment ($500 maximum) • Monthly monitoring fees ($110 monthly maximum). The CFSS participant receives up to $3,000 total of personal emergency response equipment and related services per service agreement year.
	Individual Directed Goods and Services: When a participant chooses to purchase goods and services through CFSS, the cost for the goods and services is covered using the particpant's service budget. **Limitations:** Goods and Services must not exceed an individual's budget allocation.
	Financial Management Services: Financial Management Services (FMS) providers must provide their service rates to the state agency as a part of the contracting process. They are required to notify the state agency immediately of any changes to their established rates. FMS providers must make public the maximum rate(s) for their services and a public site with approved providers and rates is maintained by DHS at https://mn.gov/dhs/people-we-serve/people-with-disabilities/services/home-community/programs-and-services/fms.jsp. The rate and scope of FMS is negotiated between the participant or the participant's representative and the FMS provider, and included in the service delivery plan. FMS provider fees must be on a fee-for-service

basis and not a percentage of the participants' service budget, and may not include set up fees, base rates or other similar charges.

1915(k) State Plan HCBS

Benefit Summary

Please provide a brief general overview of the state's proposed Community First Choice (CFC) benefit, including but not limited to an overview of services, delivery method, impact on other long-term services and supports (LTSS) programs, and how services will be coordinated between the CFC program and other state services provided:

The Minnesota Department of Human Services (DHS) is redesigning its state plan PCA services to expand self-directed options under a program called Community First Services and Supports (CFSS). The Minnesota Legislature authorized DHS to implement CFSS in state statute.

CFSS is a participant-controlled method of selecting and providing services and supports that allows the participant maximum control of services and supports. The participant chooses the level of direction and management of supports by choosing to have a significant and meaningful role in management of services and supports, including directly employing support workers with the necessary supports to perform that function. This would include services available under both fee for service and managed care. CFSS provides supports to participants to help them remain independent in the community.

CFSS will cover the following services and supports:

Assistance with activities of daily living (ADLs) (e.g., eating, bathing, grooming, and transferring);

- Assistance with health-related tasks;
- Assistance with instrumental activities of daily living (IADLs) (e.g., shopping, cooking, laundry, and assistance with medications);
- In accordance with 42 CFR 441.520, assistance is provided through hand-on assistance, supervision, and /or cueing;
- Support with acquisition, maintenance, and enhancement of skills necessary to accomplish ADL, IADL and health related tasks;
- Purchase of individual backup systems to ensure continuity of services and supports (back-up support and personal emergency response system);
- Purchase of goods and services to replace human assistance and increase independence;
- Payment to the participant's spouse, parents, stepparents, or unpaid legal guardians to serve as the participant's direct support worker providing personal care;
- Participant-specific worker training and development budget for direct support workers providing personal care; and
- Consultation service to provide the participant with support for: voluntary training/education, assisting the participant with writing the participant's service delivery plan and managing services available through the CFC benefit.

CFSS has two service delivery models: the provider agency model and the budget model. In both models, the participant:

- Directs their own care;
- Selects their worker, including their spouse or parent of a minor;

- Writes their plan with assistance from the consultation services provider, as desired; and
- Purchases goods; and

back-up systems

In the provider agency model, the participant selects an agency that serves as the support worker's employer. This means the agency recruits, hires (including workers selected by the participant, if the worker meets qualifications), trains, supervises, and pays the CFSS worker.

In the budget model, the participant is the employer of their own support workers. The participant recruits, hires, trains and supervises their CFSS worker. The person selects a financial management services (FMS) provider to help the person comply with applicable employment-related laws.

Participants who currently receive state plan PCA services will not experience any loss or interruption of services.

Coordination with other services:
The CFSS program is comprised of the §1915(k) benefit and the §1915(i) benefit to provide Personal attendant services and supports to people who meet an institutional level of care (via the §1915(k) benefit) and people who do not meet an institutional level of care (via the §1915(i) benefit). These two components of CFSS are designed to work together seamlessly to provide appropriate services to people who have a functional need.

Consultation services will be authorized and available while the participant is receiving state plan PCA services. PCA services will continue to be authorized until the participant has been served by the consultation services provider, decisions for CFSS services have been made, and CFSS services have been authorized.

Current Personal Care Agency (PCA) providers are given the opportunity to transition to be CFSS agencies. All PCA agencies will make an independent business decision as to whether they wish to be a CFSS agency. Beneficiaries of PCA services will continue to have a choice in PCA providers during the transition to CFSS. At the time of transition to CFSS, beneficiaries will be able to choose from available providers who chose to transition to CFSS agencies. DHS will accept applications for CFSS agencies on a rolling basis.

Community First Choice Development and Implementation Council

Name of State Development and Implementation Council:

Community First Services and Supports Development and Implementation Council

Frequency of Meetings:

The Community First Services and Supports Development and Implementation Council has met at varied intervals over the years but currently meets quarterly throughout the year.

Date of first Council meeting:

Nov. 19, 2012

Date of all council meetings held to date:
2012:
October 17th
November 19th

2013:
January 17th
February 21st
April 4th
June 6th
July 30th
August 21st
October 24th
November 13th
December 16th

2014:
January 16th
March 12th
June 16th
September 15th
October 14th
November 19th

2015:
January 12th
May 19th
September 14th
December 7th

2016:
February 8th
June 6th
December 9th

2017:
April 3rd
September 29th
December 4th

2018:
February 6th
June 18th
July 19th
September 17th

2019:
January 14th
June 24th
September 17th

2020:
March 16th
June 15th
September 12th

2021:
January 7th
February 4th
June 17th
December 7th

2022:
March 8th
June 8th
September 14th
December 14th

2023
March 8th
June 14th

☒ Box Checked: The state has consulted with its Development and Implementation Council before submitting its CFC State Plan amendment.

☒ Box Checked: The state has consulted with its Development and Implementation Council on its assessment of compliance with home and community-based settings requirements, including on the settings the state believes overcome the presumption of having institutional qualities.

☒ Box Checked: The state has sought public input on home and community-based settings compliance beyond the Development and Implementation Council. If yes, please describe.

DHS sought public input on HCBS settings compliance through the Statewide Transition Plan for HCBS waivers (PDF).

A significant component of Minnesota's public engagement efforts included collaboration with the HCBS rule advisory group through:

- Providing input on the development of DHS' HCBS settings rule statewide transition plan;
- Developing policy expectations and practice considerations;
- Testing the provider-attestation process and providing technical assistance throughout the attestation process;
- Providing input on the desk audit and site visit processes and protocols; and
- Providing technical assistance to providers about the desk audit follow-up and site visits

DHS also seeks public input prior to submitting any settings to CMS for heightened scrutiny review.

Community First Choice Eligibility

☒ Box Checked: Individuals are eligible for medical assistance under an eligibility group identified in

the state

☒Box checked: Categorically Needy Individuals

☒ Box Checked: Medically Needy Individuals

☒ Box Checked: Medically Needy individuals receive the same services that are provided to Categorically Needy individuals

☐ Box unchecked: Different services than those provided to Categorically Needy individuals are provided to Medically Needy individuals. (If this box is checked, a separate template must be submitted to describe the CFC benefits provided to Medically Needy individuals)

The state assures the following:

☒ Box Checked: Individuals are in eligibility groups in which they are entitled to nursing facility services, or

☐ Box Unchecked: If individuals are in an eligibility group under the state plan that does not include nursing facility services, and to which the state has elected to make CFC services available (if not otherwise required), such individuals have an income that is at or below 150 percent of the Federal poverty level (FPL)

Level of Care

☒ Box Checked: The state assures that absent the provision of home and community-based attendant services and supports provided under CFC, individuals would require the level of care furnished in a long term care hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an institution providing inpatient psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over.

Recertification

☐ Box Unchecked: The state has chosen to permanently waive the annual recertification of level of care requirement for individuals in accordance with 441.510(c)(1) & (2).

Please indicate the levels of care that are being waived:

☐ Box Unchecked: Long-term care hospital

☐ Box Unchecked: Nursing facility

☐ Box Unchecked: Intermediate care facility for individuals with intellectual disabilities

☐ Box Unchecked: Institution providing psychiatric services for individuals under age 21

☐ Box Unchecked: Institution for mental diseases for individuals age 65 or over

Describe the state process for determining an individual's level of care:

Long Term Hospital LOC

A certified assessor or public health nurse completes an in-person initial assessment. Redetermination

of level of care through reassessment must be performed at least annually. The results of the level of care assessment are summarized on the Long-Term Care Screening Document (PDF), Developmental Disabilities Screening Document (PDF) or a type B service agreement, which is an authorization document for persons who are not on a waiver program.

The person must:

- have both predictable health needs and the potential for status changes that could lead to rapid deterioration or life-threatening episodes because of the person's health condition;
- require professional nursing assessments and intervention multiple times during a 24-hour period to maintain and prevent deterioration of health status;
- require a 24-hour plan of care, including a back-up plan, to reasonably ensure health and safety in the community; and
- require frequent or continuous care in a hospital without services.

Nursing Facility LOC and Individual with Intellectual Disabilities

A certified assessor or public health nurse completes an in-person initial assessment. Redetermination of level of care through reassessment must be performed at least annually. The results of the level of care assessment are summarized on the Long-Term Care Screening Document (PDF), Developmental Disabilities Screening Document (PDF) or a type B service agreement, which is an authorization document for persons who are not on a waiver program.

Younger than age 21 psychiatric institution level of care

For younger than age 21 psychiatric institution level of care, the participant must meet the criteria defined under eligibility categories for children with disabilities in accordance with Minnesota state law. Level of care eligibility is determined by the State Medical Review Team (SMRT).

Institution for mental disease (IMD) level of care for individuals age 65 and older

For IMD level of care, the participant must meet one of the five categories of need below.

1. Does/would live alone or be homeless without current housing type and meets one of the following criteria:
    a. Has had a fall resulting in a fracture within the last 12 months
    b. Has a sensory impairment that substantially impacts functional ability and maintenance of a community residence
    c. Is at risk of maltreatment or neglect by another person, or is at risk of self-neglect
2. Has a dependency in four or more activities of daily living (ADLs)
3. Has significant difficulty with memory, using information, daily decision-making or behavioral needs that require intervention
4. Needs the assistance of another person or constant supervision to complete toileting, transferring or positioning, and this assistance cannot be scheduled
5. Needs formal clinical monitoring at least once a day

Tools and policies

The following tools and related polices are used to determine a participant's level of care:

- MnCHOICES assessment or Minnesota Long-Term Care Consultation Services Assessment Form (PDF)
- Nursing Facility level of care:
  - Nursing Facility Level of Care Criteria Guide (PDF)
- ICF/DD level of care:
  - Case Manager's Guide to Determining ICF/DD Level of Care for ICF/DD (PDF)

Informing Individuals Potentially Eligible for the Community First Choice Option

Indicate how the state ensures that individuals potentially eligible for CFC services and supports are informed of the program's availability and services:

☒ Box checked: Letter

☒ Box checked: Email

☒ Box checked: Other – Describe:

Please describe the process used for informing beneficiaries:

Prior to implementation, DHS will send a direct mailing to all participants receiving PCA services that explains CFSS and how it will affect them. DHS will use other communication methods as appropriate, which may include email distribution lists, statewide webinars, Facebook live events and informational resources through Disability HUB MN to inform both existing and new beneficiaries of the CFSS benefit.

All individuals seeking Long Term Services and Supports will undergo a comprehensive assessment. Once the assessment is completed, they will be told about all services for which they may be eligible, including CFSS.

Assurances (All assurances must be checked).

☒ Box checked: Services are provided on a statewide basis.

☒ Box checked: Individuals make an affirmative choice to receive services through the CFC option.
☒ Box checked: Services are provided without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual needs to lead an independent life.

☒ Box checked: Individuals receiving services through CFC will not be precluded from receiving other home and community-based long-term care services and supports through other Medicaid state plan, waiver, grant or demonstration authorities.

☒ Box checked: During the period that begins January 1, 2014 and extends through September 30, 2023 (or other date as required by law), spousal impoverishment rules are used to determine the eligibility of individuals with a community spouse who seek eligibility for home and community-based services provided under §1915(k).

CFC Service Models

Indicate which service models are used in the state's CFC program to provide consumer-directed home and community-based attendant services and supports (Select all that apply):

☒ Box checked: Agency-Provider Model

☐ Box unchecked: Self-Directed Model with Service Budget

☒ Box checked: Other Service Model. Describe:

Minnesota will use a variation of the self-directed model with service budget as described in the code of federal regulations under 42 CFR §441.545(c), heretofore referred to as the "budget model."

Under the budget model, participants have budget and employer authority and accept more responsibility and control over the services and supports described and budgeted within their person-centered service delivery plan.

County human services agencies (hereinafter "county" or "counties"), tribal human services organizations, managed care organizations, or Consultation Service Providers (the provider type providing voluntary support as required under CFC benefit) may identify that a person is unable to fulfill their obligations under the budget model. The consultation service provider may recommend to the county, tribal human services organization, or managed care organization that a person may benefit from a participant representative. The county, tribal human services organization, or managed care organization may require the participant to identify a representative to act on their behalf.

The budget model is similar to the self-directed model with service budget, but with the following differences:

- State established minimum qualifications for personal care attendants as outlined in the SPA
- A minimum wage floor that is governed by a collective bargaining agreement that outlines what personal care attendants must be paid

Please complete the following section if the state is using the Self-Directed Model with Service Budget or the Other Service Model if it includes a Service Budget.

Financial Management Services (FMS)

The state must make available financial management services to all individuals with a service budget.

The state will claim costs associated with financial management services as:

☒ Box checked: A Medicaid Service

☐ Box unchecked: An Administrative Activity

☒Box checked: The state assures that financial management service activities will be provided in accordance with the code of federal regulations under 42 CFR 441.545(B)(1).

If applicable, please describe the types of activities that the financial management service entity will be providing, in addition to the regulatory requirements at 42 CFR 441.545(B)(1).

Participants using the budget model must select an FMS provider. The role of the FMS provider is to support the participant to fulfill their responsibilities in being the employer of their workers. The FMS

provider is responsible to:

- Collect and process timesheets of the participant's support workers;
- Process payroll, withholding, filing, and payment of applicable federal, state and local employment-related taxes and insurance;
- Separately manage budget funds and expenditures for each participant;
- Track and report disbursements and balances of each participant's funds;
- Process and pay invoices for services in the person-centered service delivery plan;
- Provide individual periodic reports of expenditures and the status of the approved service budget to the participant or their representative and DHS, as well as the consultation services provider and the county, tribal human services organization, or managed care organization as applicable;
- Initiate background studies for CFSS support workers;
- Help the participant obtain workers' compensation insurance;
- Educate the participant on how to employ workers;
- Ensure what the participant spends their funds on follows the rules of the program and the approved plan; and
- Process the purchase of goods and services if the provider of goods or services is not a Minnesota Health Care Programs (MHCP) enrolled provider.

Specify the type of entity that provides financial management services:

☐ Box unchecked: State Medicaid Agency

☐ Box unchecked: Another State Agency – Specify:

☒ Box checked: Vendor Organization Describe:

FMS provider means a qualified organization required for participants using the budget model that is an enrolled provider with DHS to provide vendor fiscal/employer agent FMS services. DHS contracts with all FMS providers to provide FMS services. DHS determines if FMS providers meet the qualifications through a request for proposal (RFP) process every 5 years in order to continue to offer participants a choice in qualified providers of Financial Management Services. This timeline enables DHS to have increased scrutiny as required under federal law to ensure the providers have a readiness review completed by a certified national organization specializing in, and qualified to, maintain compliance with Federal, State and Local tax rules, specifically as they pertain to participant-directed services. This interval further enables DHS to ensure quality assurance and program integrity through careful monitoring and quality assurance activities occurring throughout the contract period. While this process exists, the state allows for continuous provider enrollment for any qualified Medicaid provider in accordance with the free choice of provider statute and implementing regulations, including 42 CFR 431.51 for all provider types. Any provider reaching out to DHS who meets the criteria outlined in the last posted RFP as well as other state and federal provider qualifications would be permitted to begin the contracting and enrollment process.

All FMS providers must:

- Enroll as a Medical Assistance Minnesota Health Care Programs (MHCP) provider and meet all applicable provider standards and requirements;
- Comply with background study requirements in accordance with state statute and maintain documentation of background study requests and results;
- Successfully complete a readiness review before enrollment, conducted by an individual or organization that meets the qualifications required by the state;
- Have knowledge of and compliance with Internal Revenue Service (IRS) requirements;
- Provide services statewide;
- Meet the requirements under a collective bargaining contract; and
- Process the purchase of goods and services if the provider of goods or services is not a Minnesota Health Care Programs (MHCP) enrolled provider.

Other Payment Methods

☐ Box unchecked: The state also provides for the payment of CFC services through the following methods:

☐ Box unchecked: **Use of Direct Cash Payments** - The state elects to disburse cash prospectively to CFC participants. The state assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing

functions themselves. Describe:

☐ Box unchecked: Vouchers - Describe:

Service Budget Methodology

Describe the budget methodology the state uses to determine the individual's service budget amount. Also describe how the state assures that the individual's budget allocation is objective and evidence based utilizing valid, reliable cost data and can be applied consistently to individuals:

The CFSS service budget amount is based on an assessment of the participant's personal care needs as defined in state statute. The service budget amount is based on an objective assessment of the participant's needs. The assessment must be conducted by a trained and certified assessor as defined in state statute. All components of this process adhere to 42 CFR 441.560. DHS acknowledges that the assessment process is an administrative function.

Using a statistical model, the county, tribal human services organization, or managed care organization arrives at a total dollar and service amount, based on a needs assessment.

After the needs assessment is completed, the assessor provides (by mail or in person) the participant with a written summary outlining their needs for care and options for services and supports, including their service authorization amount for CFSS (units of service or dollar amount). The participant works with their consultation services provider to receive voluntary support to the extent desired, to understand the amount of their individual CFSS services and supports, to determine how the funds will be used and provides assistance to the participant as needed to finalize the service plan. If the participant is enrolled in a §1915(c) HCBS waiver or if the participant is age 65 or older and enrolled in managed care, the participant works with the 1915(c) case manager or Managed Care coordinator to

finalize the plan for use of CFSS services, as well as additional services under the expanded service menu of one of DHS' five §1915(c) HCBS waivers to meet their needs. Participants use their service budget to:

- Directly employ and pay qualified support workers;
- Obtain covered goods as defined under the optional services and supports;
- Select and pay for FMS services based on the DHS published rates; and
- Purchase back-up systems

The consultation services provider is responsible to review the CFSS service delivery plan written by the participant or their representative. In supporting the person, they will review whether the plan meets assessed needs outlined in the needs assessment and contains covered CFSS services. The consultation services provider then submits the plan for approval to the State Medicaid agency or its delegated county, tribal human services organization, or managed care organization. If the participant is enrolled in a 1915(c) waiver or managed care, the case manager or care coordinator will provide a final review of the plan of care on behalf of the state. The state Medicaid agency oversees final approval of all plans of care.

Consultation services and worker training and development are authorized on a per-diem basis and do not count against a participant's CFSS service budget.

Six consultation service sessions are initially allocated for each participant and additional sessions approved by DHS as requested.

The CFSS service delivery plan must include a detailed plan for worker training and development. In the agency model the CFSS provider agency arranges for worker training and development. In the budget model the participant, as the employer, arranges for worker training and development. The plan must include what components of worker training and development will be used, when the components will be used, how they will be provided and how these relate to the participant's individual needs. Components include, but are not limited to:

- Support worker training on the participant's individual assessed needs;
- Tuition for professional classes for the support workers related to the participant's assessed needs;
- Direct observation, monitoring and documentation of support worker skills and tasks; and
- Activities to evaluate CFSS services and ensure worker competency

A separate budget for worker training and development is available to employers of CFSS workers (i.e., CFSS agency or person/representative) to pay for documentation, training, observation, monitoring and coaching of CFSS workers. These activities help CFSS workers expand their skills to support the participant's specific needs.

When a participant is eligible for and chooses to receive CFSS services:

- The participant includes a worker training and development plan in the individual service delivery plan, with support from the consultation services provider as desired;
- The county, tribal human services organization, or managed care organization authorizes worker training and development for the person; and

The CFSS agency (agency model) or FMS provider (budget model) bills for classes (either model) or employer training (agency model only).To request additional funds for the participant's worker training and development budget, the CFSS provider agency or FMS provider must request an increase from

DHS, the waiver case manager or the managed care organization. The entity that approves additional funds for worker training and development depends on the type of program and/or if the participant is receiving services via fee-for- service or managed care.

The CFSS provider agency or FMS provider must submit the following documentation to the appropriate entity (DHS, waiver case manager, MCO) for authorization of additional funds:

- Request for the specific dollar amount for the increase to the worker training and development budget;
- Reason for increasing the worker training and development budget; and
- Documentation of completed worker training and development tasks and related spending for the current service delivery plan.

The state recognizes that worker training and development for support workers is considered an administrative service.

Describe how the state informs the individual of the specific dollar amount they may use for CFC services and supports before the person-centered service plan is finalized:

After the assessment is completed, the assessor will provide (by mail or in person) the participant with a written summary outlining their needs for care and options for services and supports, including the specific budget allocation amount. The participant or their representative is responsible to write the CFSS service delivery plan. DHS has provided a standardized service delivery plan template to use. Consultation services are available to the participant and/or their representative to provide assistance and support in writing the CFSS service delivery plan, to the extent desired by the participant and this service does not come out of the service budget. The plan will include how the participant will use funds for staff and goods/services.

The consultation services provider is responsible to review the CFSS service delivery plan written by the participant or their representative. In supporting the person, they will review whether the plan meets assessed needs outlined in the needs assessment and contains covered CFSS services. The consultation services provider then submits the plan for approval to the State Medicaid agency or its delegated county, tribal human services organization, or managed care organization. If the participant is enrolled in a 1915(c) waiver or managed care, the case manager or care coordinator will provide a final review of the plan of care on behalf of the state. The state Medicaid state agency oversees final approval of all plans of care.

Plan approval includes ensuring the plan meets requirements and does not include services or goods that are not covered.

The State Medicaid Agency or their delegate sends copies of the approved plan to the participant and the CFSS provider agency and/or FMS provider, depending on the service model the person has chosen.

For participants who are using the provider agency model, the CFSS provider agency is responsible to work with the participant to fill in any additional service delivery details not included in the plan approved by the consultation services provider.

Describe how the individual may adjust the budget, including how he or she may freely change the budget and the circumstances, if any, which may require prior approval of the budget change from the

state:

A participant might experience a change in condition or health status that results in an increased need for CFSS services.

A participant with a temporary change in condition (45 days or less) may be eligible for a 45-day temporary increase. The CFSS provider (agency model) or the participant (budget model) must notify the county, tribal human services organization, managed care organization, or FMS provider of the change in condition so the 45-day telephonic reassessment can be completed and the total number of units/dollars can be adjusted.

A participant with a change in condition expected to last longer than 45 days requires a full in-person reassessment to determine their eligibility and a new service authorization before the temporary service increase expires.

Adding goods and/or services to the budget mid-year requires prior approval.

Describe the circumstances that may require a change in the person-centered service plan:

A participant's CFSS service delivery plan (person-centered service plan) must be updated in the following situations:

- When there is a change in the participant's condition, tasks, procedures, living arrangements, representative or planned monthly use of units; or
- Annually at the time of the reassessment.

Describe how the individual requests a fair hearing if his or her request for a budget adjustment is denied or the amount of the budget is reduced:

When a budget is reduced, denied or terminated, the county or tribal human services organization provides the participant with a Notice of Action (Service Plan) (PDF). The notice of action includes:

- The reason (including the legal basis) for the decision and corresponding action;
- The timeline associated with the action;
- Information about the appeals process, including how to file an appeal if the participant disagrees with the decision, timelines and the participant's right to request continuation of services during an appeal

MCOs must notify their enrolled members with written notice of denial of payment or the denial, termination or reduction (DTR) of services that the member or the member's health care provider requested. This notice includes:

- The action the MCO is taking;
- The reason the MCO is taking this action;
- The state and federal laws or MCO policies that support the MCO's action; and
- The process the member must follow to file an appeal with the MCO or the state

Describe the procedures used to safeguard individuals when the budgeted service amount is insufficient to meet the individual's needs:

The county, tribal human services organizations, or managed care organization provides an assessment summary to the participant in writing. The summary identifies appropriate CFSS supports and services that would meet the participant's assessed needs. The participant works with the consultation services provider to understand any limits to the individual services and supports.

Additionally, the following safeguards are in place:

- The participant may be eligible for additional services offered through both Medicaid and non-Medicaid programs in addition to state plan CFSS services.
- All CFSS participants may be eligible for a 45-day temporary increase. The CFSS provider (agency model) or the participant (budget model) must notify the county, tribal human organization, or managed care organization or FMS provider of the change in condition so the total number of units/dollars can be adjusted. A participant with a change in condition longer than 45 days requires a reassessment to determine their eligibility and a new service authorization.

When a budget, good or service is reduced, denied or terminated, the county, tribal human services organization, or managed care organization provides the participant with a Notice of Action (Service Plan) (PDF). The notice of action includes:

- The reason (including the legal basis) for the decision and corresponding action;
- Timeline associated with the action; and
- Information about the appeals process, including how to file an appeal if the participant disagrees with the decision, timelines and the participant's right to request continuation of services during an appeal.

MCOs must notify their enrolled members with written notice of denial of payment or the denial, termination or reduction (DTR) of services that the member or the member's health care provider requested. This notice includes:

- The action the MCO is taking;
- The reason the MCO is taking this action;
- The state and federal laws or MCO policies that support the MCO's action; and
- The process the member must follow to file an appeal with the MCO or the state

Describe how the state notifies individuals of the amount of any limit to the individual's CFC services and supports:

After the assessment is completed, the assessor will provide (by mail or in person) the participant with a written summary outlining the needs for care and options for services and supports to meet the assessed needs, including the service unit amount. The participant works with the consultation services provider to understand the dollar and unit amount determined in the assessment process, as well as any limits to the individual services and supports, including how the funds for staff and goods will be used. If the participant is enrolled in a §1915(c) HCBS waiver, or if the participant is age 65 or older and enrolled in managed care, the participant works with the case manager or care coordinator to finalize the plan (after working with the consultation services provider) for use of CFSS services, as

well as additional services under the expanded service menu of one of DHS' five §1915(c) HCBS waivers to meet the needs.

Describe the process for making adjustments to the individual's budget when a reassessment indicates there has been a change in his or her medical condition, functional status, or living situation:

A participant might experience a change in condition or health status that results in an increased need for CFSS services, including during the time of reassessment.

A participant with a temporary change in condition (45 days or less) may be eligible for a 45-day temporary increase. The CFSS provider (agency model) or the participant (budget model) must notify the county, tribal human services organization, managed care organization, or FMS provider of the change in condition so the total number of units/dollars can be adjusted.

A participant with a change in condition longer than 45 days requires a reassessment to determine the budget amount and create a new service authorization.

Mandatory Services and Supports

1. Assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hand-on assistance, supervision, and/or cueing.

Identify the activities to be provided by applicable provider type and describe any service limitations related to such activities.

☒ **Box checked: Personal Attendant Services. Describe:**

Personal attendant services include assistance to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related procedures and tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task. Personal care attendant services may also include observation and redirection to the participant for episodes of behavior impacting ADLs and IADLs as well as preventing harm to self and others that need redirection, as identified in the CFSS service delivery plan.

ADLs include dressing, grooming, bathing, eating, transfers, mobility, positioning and toileting.

IADLs include activities related to living independently in the community, such as attending medical appointments, providing or assisting with transportation, paying bills, communicating by telephone or other media, completing household tasks necessary to support the participant with an assessed need, such as planning and preparing meals or shopping for food, clothing and other essential items.

Health-related procedures and tasks are procedures and tasks performed by a support worker that can be delegated or assigned by a health care professional licensed in accordance with Minnesota state law. Health-related procedures and tasks may include assistance with self-administered medications, interventions for seizure disorders, range-of-motion and passive exercise, clean tracheostomy suctioning and services to a participant who uses ventilator support or other activities within the scope of CFSS that meet the definition of health-related procedures or tasks.

Personal attendant services may be delivered individually (1:1) or as shared care (1:2 or 1:3).

The participant's spouse or parents, stepparents or unpaid legal guardians may be direct support

workers providing personal care.

Personal attendant services do not include:

- CFSS provided by a participant's representative or paid legal guardian
- Services that are used solely as a child care or babysitting service
- Services that are the responsibility or in the daily rate of a residential or program license holder under the terms of a service agreement and administrative rules
- Sterile procedures
- Injections into veins, muscles or skin
- Homemaker services that are not an integral part of the assessed CFSS service
- Home maintenance or chore services
- Home care services, including hospice services if chosen by the participant, covered by Medicare or any other insurance held by the participant
- Services to other members of the participant's household
- Services not specified as covered under Medical Assistance as CFSS
- Application of restraints or implementation of deprivation procedures
- Independent determination of the medication dose or time for medications for the participant

The amount of personal care attendant service units is determined based on the person-center assessment using the MnCHOICES tool. Units are authorized in 15-minute increments. The maximum number of units is 112 per day based on the individual's needs. Services units are permitted to be used flexibly within the individual's service authorization period.

As outlined in our assurances and the service budget methodology sections of this SPA, individuals whose needs exceed the personal care benefit allowance under the state plan are eligible for a temporary 45 day increase in services. A participant with a change in condition that is expected to last longer than 45 days must have a reassessment to determine their eligibility and receive a new service authorization. The participant may then be eligible for additional services offered through both Medicaid and non-Medicaid programs in addition to state plan CFSS services. This includes extended personal care attendant services that are authorized under a 1915(c) waiver that may exceed the state plan limits.

Those meeting criteria for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit will not have limitations on the amount of personal attendant units authorized.

Provider Type: Support worker

License Required: No

Certification Required. Yes Describe: Standardized certification training

Education-Based Standard. No Describe:

Other Qualifications Required for this Provider Type. Yes Describe:

All CFSS support workers, regardless of service delivery model must:

- Complete the standardized certification training and pass the "Personal Care Assistance (PCA)

and Community First Services and Supports (CFSS) Training and Test"

- Pass a background study initiated by the CFSS provider agency/FMS provider as required under the state's background study law
- Enroll with Minnesota Health Care Program as a PCA/CFSS support worker
- Be able to communicate effectively with the participant and the provider agency/FMS provider
- Have the skills and ability to provide the services and supports according to the participant's CFSS service delivery plan and respond appropriately to the participant's needs.

The participant may establish additional CFSS support worker qualifications.

Under the provider agency model, the provider agency must verify and maintain evidence of support worker competency, including documentation of the support worker's:

- Education and experience relevant to the job responsibilities assigned to the support worker and the participant's needs
- Relevant training received from sources other than the provider agency
- Orientation and instruction to implement services and supports to meet the participant's needs and preferences identified in the CFSS service delivery plan
- Periodic performance reviews completed by the supervising professional(s) at the provider agency at least annually

Under the budget model, the participant or their representative is responsible to:

- Hire the support worker(s)
- Ensure that support workers are competent to meet the participant's assessed needs and additional requirements identified in the CFSS service delivery plan
- Verify and maintain evidence of support worker competency, including documentation of the support worker's:
    - Education and experience relevant to the job responsibilities assigned to the support worker and the participant's needs
    - Training received from sources other than the participant
    - Orientation and instruction to implement defined services and supports to meet the participant's needs and preferences identified in the CFSS service delivery plan
    - Periodic written performance reviews completed by the participant at least annually

Limitations:
CFSS support workers are limited to providing 310 hours of care per calendar month, regardless of the number of participants they serve or the number of agencies or participants that employ the support worker.

The participant's spouse or the parents, stepparents or unpaid legal guardians of a person under age 18 may be direct support workers providing personal care. These support workers cannot provide any Medical Assistance home and community-based services (HCBS) in excess of the following:

- If multiple parents are support workers providing CFSS services to their minor child or children, each parent may provide up to 40 hours of medical assistance home and community-based services in any seven-day period regardless of the number of children served. The total number of hours of medical assistance home and community-based services provided by all of the parents must not exceed 80 hours in a seven-day period regardless of the number of children served.

- If only one parent is a support worker providing CFSS services to the parent's minor child or children, the parent may provide up to 60 hours of medical assistance home and community-based services in a seven-day period regardless of the number of children served.
- If a participant's spouse is a support worker providing CFSS services, the spouse may provide up to 60 hours of medical assistance home and community-based services in a seven-day period.
- For parents of minor children and spouses, the limitations set forth above apply to the total amount of hours per family regardless of the:
    - Number of parents
    - Combination of parent(s) and spouse
    - Number of children who receive 1915(i) benefits.
- Paid legal guardians are not allowed to be the support worker, whether the participant is a minor or an adult.

☐ Box unchecked: Companion Services. Describe:

Provider Type:

License Required

Certification Required. Describe:

Education-Based Standard. Describe:

Other Qualifications Required for this Provider Type. Describe:

☐ Box unchecked: Homemaker/Chore Service. Describe:

Provider Type:

License Required:

Certification Required. Describe:

Education-Based Standard. Describe:

Other Qualifications Required for this Provider Type. Describe:

☐ Box unchecked Other Services. Describe:

Provider Type:

License Required:

Certification Required. Describe:

Education-Based Standard. Describe:

Other Qualifications Required for this Provider Type. Describe:

2. The acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish

ADLs, IADLs, and health-related tasks.

Identify the activities to be provided by applicable provider type and any describe any service limitations related to such activities:

Personal attendant services as described above may include functional skills training through hands-on assistance, supervision and cueing to accomplish the ADL, IADL and health-related tasks. Participants who are assessed to need training or assistance to acquire, maintain and/or enhance the skills necessary to accomplish ADLs, IADLs and health-related tasks will receive this support concurrently with hands-on assistance or constant supervision/and or cueing to accomplish the task as described under the personal attendant services.

Assistance to acquire, maintain and/or enhance skills will be tied specifically to the assessment and CFSS service delivery plan. This assistance is a means to maximize the participant's independence and integration in the community, preserve functioning and defer or eliminate the likelihood of future institutional placement. These services are limited to supports necessary for the participant to acquire, maintain or enhance skills to independently accomplish (to the extent possible) ADLs, IADLs and health-related tasks as described under personal attendant (personal care assistance) services.

Support workers may provide assistance under the following conditions:

- The need for skill training or maintenance activities has been determined through the assessment process and has been authorized as part of the CFSS service delivery plan
- The activities provided are concurrent with the performance of ADLs, IADLs and health-related tasks as described in the previous section
- The activities are for the sole benefit of the participant and are only provided to the participant
- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence
- The activities provided are consistent with the stated preferences and outcomes in the CFSS service delivery plan
- The support worker is competent to perform these services for the participant

Provider Type: Support worker

License Required: No

Certification Required. Yes Describe: Complete the standardized certification training and pass the "Personal Care Assistance (PCA) and Community First Services and Supports (CFSS) Training and Test"

Education-Based Standard. Describe: No

Other Qualifications Required for this Provider Type. Yes. Describe:

All CFSS support workers, regardless of service delivery model must:

- Pass a background study initiated by the provider agency/FMS provider as required under state background study law
- Enroll with Minnesota Health Care Programs as a PCA/CFSS worker
- Be able to communicate effectively with the participant and the provider agency/FMS provider
- Have the skills and ability to provide the services and supports according to the participant's

CFSS service delivery plan and respond appropriately to the participant's needs

The participant may establish additional CFSS support worker qualifications.

Under the provider agency model, the provider agency must verify and maintain evidence of support worker competency, including documentation of the support worker's:

- Education and experience relevant to the job responsibilities assigned to the support worker and the participant's needs
- Relevant training received from sources other than the provider agency
- Orientation and instruction to implement services and supports to meet the participant's needs and preferences identified in the CFSS service delivery plan.

Under the budget model, the participant or their representative is responsible to:

- Hire the support worker(s)
- Ensure that support workers are competent to meet the participant's assessed needs and additional requirements identified in the CFSS service delivery plan
- Determine the competency of the support worker through evaluation within 30 days of any support worker beginning to provide services and with any change in the participant's condition or modification to the CFSS service delivery plan
- Verify and maintain evidence of support worker competency, including documentation of the support worker's:
    - Education and experience relevant to the job responsibilities assigned to the support worker and the participant's needs
    - Training received from sources other than the participant
    - Orientation and instruction to implement defined services and supports to meet the participant's needs and preferences identified in the CFSS service delivery plan
    - Periodic written performance reviews completed by the participant at least annually

3. Individual back-up systems or mechanisms to ensure continuity of services and supports.

Identify the systems or mechanisms to be provided and limitations for:

☒ Box checked: Personal Emergency Response Systems

☐ Box unchecked: Pagers

☐ Box unchecked: Other Mobile Electronic Devices

☒ Box checked: Other. Describe: Persons identified by an individual to be included as backup

Describe any limitations for the systems or mechanisms provided:

Personal emergency response systems (PERS) covers:

- Purchase of the PERS equipment, including necessary training or instruction on the use of the equipment; and
- Installation (set up, testing) and monitoring of the device

PERS does not cover:

- Equipment used to deliver Medical Assistance or other waiver services;

- Sensing and/or monitoring systems that do not require activation by the person;
- Supervision or monitoring of ADLs provided to meet the requirements of another service;
- Telehealth and biometric monitoring devices; or
- Video equipment

The following information must be documented in the person's CFSS service delivery plan:

- The participant's assessed need for PERS;
- The type of PERS equipment the participant will use;
- How the PERS equipment will meet the participant's assessed need;
- Back-up system for PERS equipment during electrical outages or other equipment malfunctions; and
- Fees for equipment purchase, installation and monthly monitoring
- Provider Type: Personal emergency response equipment vendor

Certification Required. No

Education-Based Standard. No

Other Qualifications Required for this Provider Type: Yes Describe:

Minnesota Health Care Programs (MHCP) enrolled vendors or providers enrolled in MCO network(s) that meet one of the following qualifications:

- State medical equipment provider
- Pharmacy licensed by the Minnesota Board of Pharmacy
- Medicare-certified home health agency

Individual back-up supports:

The participant can identify individual(s) to provide back-up supports. The individual(s) chosen to provide back-up supports must be identified in the person's CFSS service delivery plan. The participant's CFSS service delivery plan must also include a description of how the participant will communicate with or summon the designated back-up supports.

- Provider Type: Support worker

License Required: No

Certification Required. Yes Describe: Complete the standardized certification training and pass the "Personal Care Assistance (PCA) and Community First Services and Supports (CFSS) Training and Test"

Education-Based Standard. Describe: No

Other Qualifications Required for this Provider Type. Yes. Describe:

All CFSS support workers, regardless of service delivery model must:

- Pass a background study initiated by the provider agency/FMS provider as required under state background study law;
- Enroll with Minnesota Health Care Programs as a PCA/CFSS worker;
- Be able to communicate effectively with the participant and the provider agency/FMS provider; and
- Have the skills and ability to provide the services and supports according to the participant's

CFSS service delivery plan and respond appropriately to the participant's needs

The participant may establish additional qualifications for individual back-up supports.

The participant or their representative is responsible to verify provider qualifications under the budget model, and DHS Provider Enrollment or the county, tribal human services organization, or managed care organization is responsible to verify provider qualifications under the agency model.

4. Voluntary training on how to select, manage and dismiss attendants.

The state will claim costs associated with voluntary training as (check one):

☐ **Box unchecked: A Medicaid Service**

☒**Box checked: An Administrative Activity**

Describe the voluntary training program the state will provide to individuals on selecting, managing and dismissing attendants:

CFSS includes consultation services, which supports participants to select, manage and dismiss support workers. This includes:

- Training the participant to interview, select, manage interactions with and dismiss support workers;
- Responding to the participant's questions related to self-directed tasks or other concerns throughout the CFSS service delivery plan year; and
- Revising the person-centered CFSS service delivery plan to achieve quality service outcomes

The consultation services provider will maintain and document routine communication with the participant to review services and plan implementation. The participant has the option to request additional ongoing support from the consultation services provider throughout the course of receiving CFSS. This may occur when the participant chooses to change their plan or when they have a change in condition that needs to be addressed in the plan. A participant using the budget model may also need support from the consultation services provider to help understand the role as the employer.

Provider Type: Consultation Services Provider

License Required: No

Certification Required. No Describe:

Education-Based Standard. Yes Describe:

Consultation services is available to participants for training on the skills needed to select, manage and dismiss qualified support workers. The consultation services provider offers this training when the participant starts the service. It is available to the participant throughout their service eligibility.

Consultation services providers are required to employ a lead professional staff member that meets certain education criteria. The lead employee must meet at least one of the following education requirements:

- Be a doctor of medicine or osteopathy;
- Be a registered nurse;

- Have a bachelor's degree or higher, or a certification as appropriate, in one of the following fields:
    - Occupational therapist
    - Physical therapist
    - Psychologist
    - Social worker
    - Speech-language pathologist or audiologist
    - Professional recreation staff
    - Professional dietitian
    - Designation as a human services professional; and
- Have at least one year of experience working directly with people with disabilities or people older than age 65 and have a degree in a discipline associated with at least one of the following fields of study:
    - Human behavior (e.g., psychology, sociology, speech communication, gerontology)
    - Human skill development (e.g., education, counseling, human development)
    - Humans and their cultural behavior (e.g., anthropology)
    - Human condition (e.g., literature, art)
    - Any other study of services related to basic human care needs (e.g., rehabilitation counseling)

Staff members working directly with participants (but not as the lead employee of a consultation services provider) must meet the education requirements listed in the lead employee education section above or meet the education substitution. These staff members can substitute one of the following for a bachelor's degree:

- Experience coordinating or directing services for people with disabilities or people older than age 65, including self-directed services; or
- Experience coordinating their own services

Other Qualifications Required for this Provider Type. Yes. Describe:

The consultation services provider must meet all of the following qualifications:

- Enroll with Minnesota Health Care Programs (MHCP);
- Employ at least one lead staff member who meets the qualifications for the lead employee;
- Have the ability to provide services statewide (either in person or remotely);
- Have an office located in Minnesota;
- Have a toll-free phone number and secure fax number;
- Have never had a county, tribal human services organization, or managed care organization contract or provider agreement discontinued due to fraud;
- Have never had any owners, managers or board members who have been disqualified under the criminal background check system; and
- Ensure employees complete all DHS-mandated training applicable to their roles

The lead employee must:

- Be age 18 or older;
- Clear a background study as required in accordance with state statute; and
- Have a minimum of two years of full-time experience in the field of self-direction

All staff members working directly with participants (but not as the lead employee) must:

- Be age 18 or older;
- Clear a background study as required in accordance with state statute

Optional Services and Supports:

Indicate which of the following optional services and supports the state provides and provide a detailed description of these benefits and any limitations applicable to them.

No Transition Costs (Provided to individuals transitioning from a nursing facility, Institution for Mental Disease, Intermediate care facility for Individuals with Intellectual Disabilities to a community based home setting) – Check all of the following costs that apply:

☐ Box unchecked: Rental and Security Deposits Description and Limitations:

☐ Box unchecked: Utility Security Deposits Description and Limitations:

☐ Box unchecked: First Month's Rent Description and Limitations:

☐ Box unchecked: First month Utilities Description and Limitations:

☐ Box unchecked: Basic Kitchen Supplies Description and Limitations:

☐ Box unchecked: Bedding and Furniture Description and Limitations:

☐ Box unchecked: Other Household Items Description and Limitations:

☐ Box unchecked: Other coverable necessities linked to an assessed need to enable transition from an institution to the community

☒ **Box checked: Goods and Services** - Services or supports for a need identified in the individual's person centered plan of services that increase an individual's independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance. Include a service description including provider type and any limitations for each service provided.

CFSS may cover the costs of goods that either:

- Increase a participant's independence; or
- Decrease a participant's need for assistance with an assessed need from another person

Expenditures for goods and services must:

- Relate to a need identified in the participant's service delivery plan;
- Be priced at fair market value;
- Increase the participant's independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance for the participant's assessed need; and

Fit within the annual limit of the participant's approved service allocation or budget Goods that are covered under the Medicaid Home health medical supplies, equipment and appliances benefit would not be covered by CFSS.

When the participant uses CFSS funds to purchase goods and services, the consultation services provider must review the CFSS service delivery plan with the person. In supporting the person, they

will review whether the good or service meets an assessed need outlined in the needs assessment and is a covered CFSS service. The consultation services provider then submits the plan to the State Medicaid agency or the delegate of the State Medicaid Agency for approval. All goods must be purchased through either a MHCP enrolled provider or an FMS provider.

When the participant uses the provider agency model and chooses to purchase goods through CFSS, the personal care units are adjusted to account for the purchase of goods and services that substitute for human assistance. When the participant uses the budget model and chooses to purchase goods through CFSS, the cost for the goods is covered using the participant's service budget as described earlier in this document.

Provider qualifications:

Entities providing goods or services covered by CFSS must bill for them through a MHCP enrolled provider or an FMS provider. All individuals or vendors of goods and services must have both of the following:

- The capability to perform the requested work and the ability to successfully communicate with the participant; and
- The necessary professional and/or commercial licenses required by federal, state and local laws and regulations, if applicable

Home and Community Based Settings

☒Each individual receiving CFC services and supports must reside in a home or community-based setting and receive CFC services in community settings that meet the requirements of the code of federal regulations 42 CFR 441.530.

Setting Types (check all that apply):

☐ Box unchecked: CFC services are only provided in private residences and are not provided in provider - owned or controlled settings.

☒ Box checked: CFC services may be provided in private residences and in provider owned or controlled settings.

☒ Box checked: The CFC benefit includes settings that have been determined home and community-based through the heightened scrutiny process.

1. Please identify all residential setting types in which an individual may receive services under the CFC benefit.

1. Participants may receive CFSS in their own home or family home.

A participant's own home is defined as a single-family home or a unit in a multi-family home (e.g., apartment) where a participant lives, and the participant or their family owns/rents and maintains control over the individual unit, demonstrated by a lease agreement (if applicable).

2. Participants may receive services in settings registered by the Minnesota Department of Health (MDH) as a board and lodge establishment.

This includes hotel, vacation rental or other locations where a participant may be visiting or residing on a temporary basis.

3. Participants may receive CFSS in residential settings that are not owned or controlled by the provider of CFC services.

   a. Participants may receive CFSS services in residential settings that are owned/controlled by the residential §1915(c) HCBS waiver service provider in the following settings:

      a. Customized living settings
      b. Integrated community supports settings

2. Please identify all non-residential setting types in which a person may receive services under the CFC benefit.

CFSS will not be provided in any non-residential waiver provider-controlled settings.

Setting Assurances– The state assures the following:

☒ Box checked: CFC services will be furnished to individuals who reside in a home or community setting, which does not include a nursing facility, institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, or a hospital providing long-term care services.

☒ Box checked: Any permissible modifications of rights within a provider owned and controlled setting is incorporated into an individual's person-centered service plan and meets the requirements of 42 CFR 441.530(a)(vi)(F).

Additional state assurances:

Community First Choice Support System, Assessment and Service Plan Support System

☒ Box checked: The support system is provided in accordance with the requirements of §441.555.

Provide a description of how the support system is implemented and identify the entity or entities responsible for performing support activities:

Consultation services

Consultation services are an integral part of the CFSS program. Consultation services include services that support the participant in the person-centered planning process. The service also provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions. Components of this service include providing required voluntary training on how to select, manage and dismiss attendants among other things. This service is available to all individuals receiving the CFSS benefit regardless of the service delivery models selected.

All participants using CFSS, regardless of service delivery method, must select a consultation services provider. Once the participant has selected a provider, the provider is responsible for delivering the supports set forth below and in accordance with the participant's needs and wishes. The participant determines the degree of support and information that is needed from the provider. Regardless of the amount of support that the participant elects to receive, the provider is responsible for submitting the completed service plan for approval to the state Medicaid agency or its delegated county, tribal human services organization, or managed care organization.

Consultation service providers assist the participant with understanding CFSS, planning for services, choosing a model, creating and implementing the CFSS service delivery plan to the extent desired by the participant. Consultation Service providers may:

- Educate about service options
- Educate about choices in providers
- Educate about rights and responsibilities (including appeal rights)
- Educate the participant about CFSS
- Educate the participant about the agency model and budget model
- Assure a person-centered planning process
- Help the participant or the participant's representative write, implement and evaluate their CFSS service delivery plan (to the extent the participant desires)
- Assist participants who have chosen the budget model with outlining a budget
- Provide the participant with a list of CFSS agency providers (if the participant chooses the agency model) or financial management services (FMS) providers (if the participant chooses the budget model).
- Training the participant to recruit, select, train, schedule, supervise, direct, evaluate and dismiss support workers
- Responding to participant's questions related to self-directed tasks or other concerns throughout the CFSS service delivery plan year
- Completing a semi-annual review if the participant does not have a case manager/care coordinator and the spouse or parent (if a minor) serves as the support worker
- Revise a person-centered CFSS service delivery plan to achieve quality service outcomes

When a participant uses the budget model, the consultation services provider may provide these additional functions:

- Monitor the participant's success in using the budget model and re-educate and/or recommend involuntary exit, if needed
- Work with the FMS provider to provide the participant with ongoing support to serve as the employer of their support workers
- Answering the participant's questions related to being a participant employer during check-ins (frequency based on an individuals needs as identified in consultation services provider agreement with the participant).
- Check in with the participant to ask if they are completing employer tasks, such as:
    - Ensuring the support workers are competent to meet the participant's needs
    - Orienting and training support workers
    - Evaluating support workers within 30 days of hire, the start of a new plan year or after a change in condition
    - Verifying and maintaining evidence of support worker competency, including documentation

- Completing support worker performance reviews at least once per year (frequency based on an individuals needs as identified in consultation services provider agreement with the participant).
- Answering the participant's questions during check-ins (frequency based on an individuals needs as identified in consultation services provider agreement with the participant).

The consultation service provider will maintain and document routine communication with the participant to review services and plan implementation. The participant has the option to request additional ongoing support from the consultation service provider when needed. This may occur when the participant chooses to change their plan or they have a change in condition that needs to be addressed in the plan. A participant using the budget model may also request support from the consultation service provider to assist with understanding their role as the employer.

Consultation service providers provide additional support if a CFSS participant is not carrying out their duties under the budget model. The consultation service provider will develop an individualized plan to provide additional training, check-ins or other assistance to ensure the participant is completing employer tasks. The consultation service provider will document outcomes of the additional supports and training, and may recommend involuntary exit to DHS/county, tribal human services organization, or managed care organization, if needed.

Additional responsibilities and expectations of consultation service providers:

- Help DHS/county, tribal human services organization, or managed care organization with surveys and data collection, at request
- Document complaints received for possible audit
- Have policies and procedures to meet the needs of culturally diverse participants receiving services
- Review their grievance policy annually
- Pass on information from DHS/county, tribal human services organization, or managed care organization (e.g., policy clarifications or changes) to participants using CFSS when requested by DHS
- Comply with all requirements, as applicable.

Provider qualifications

See the provider qualifications for consultation services providers under the "voluntary training on how to select, manage and dismiss attendants" section of the mandatory services and supports.

Authorization of consultation services

Consultation service providers provide support services (such as: orientation/annual, ongoing support, remediation) as sessions. Only one session can be billed by a Consultation services provider in a single day. Consultation service sessions are initially allocated for each participant and additional sessions approved by DHS as requested. See the budget methodology section for additional information.

Additional supports

Worker training and development

Worker training and development is a function of CFSS that pays for the training, observation, monitoring and coaching of CFSS support workers as required under 42 CFR 441.565. Participants have the right to access other training provided by or through the State so their attendant care provider can

meet any additional qualifications required or desired by the participant. These activities help CFSS support workers gain the skills to support the participant's specific needs. Under the provider agency model, the CFSS agency is the employer of the support worker. Under the budget model, the participant (or their representative) is the employer of the support worker. The support worker's employer is responsible to train, supervise and evaluate the support worker's competency. The employer must orient each support worker to the participant's needs and train them on the tasks the participant needs.

All participants must have a worker training and development plan included in their CFSS service delivery plan. The plan must describe:

- What training the participant's support workers need
- Who provides the training and the license, education, training or work experience the trainer needs
- Who determines the support worker is competent to provide the service the participant needs
- A plan to supervise and evaluate the support workers
- A plan to evaluate whether the overall service delivery is meeting the participant's needs

The employer must update the worker training and development plan in all of the following situations:

- At reassessment
- When a new support worker begins providing services to the participant
- When there are significant changes to the participant's service delivery plan
- When a performance review indicates a support worker needs additional training.

In the CFSS agency model, a CFSS provider agency staff member with a background relevant to the needed task trains and ensures the support worker is competent.

In the CFSS budget model, the participant is responsible to train and ensure the support worker is competent to perform the needed task. The participant or their representative cannot use the worker training and development budget to pay themselves to meet their employer responsibilities. The participant or their representative also cannot hire another individual to supervise their support workers.

In both the CFSS agency and budget models, the support worker's employer can use the CFSS worker training and development budget to pay the fees for a support worker attending a class or workshop on topics related to the participant's assessed needs. A class can take place in a variety of settings and have varying numbers of learners (e.g., one-on-one training, traditional classroom course, online class).

Worker training and development has a minimum annual allocation of $1,272.96 credited to each participant and is separate from the participant's service delivery budget. Additional funds for the participant's worker training and development may be requested and are subject to DHS approval. DHS understands that worker training and development for the support worker is considered an administrative service.

Specify any tools or instruments used as part of the risk management system to identify and mitigate potential risks to the individual receiving CFC services:

Assessment and service/support planning

The comprehensive assessment tool is used to determine eligibility for CFSS. It contains assessment questions intended to help discover any potential risks to document in the CFSS service delivery plan. Assessors are responsible to identify issues that may affect the participant's health and safety.

The support plan, informed by the assessment, provides information to the participant, provider agency, support worker and consultation services provider. The support plan includes:

- Documentation of dependencies in ADLs and IADLs, presence of health-related needs and presence of level-one behaviors
- Determination of institutional level of care
- Determination of the participant's representative, if needed
- Identification of appropriate paid, unpaid and natural supports and services
- Referrals to appropriate payers and community resources
- Documentation of the plan to mitigate any identified risks

An assessor is a mandated reporter and is required to report any suspected maltreatment of a vulnerable adult to the Minnesota Adult Abuse Reporting Center (MAARC) and to report any suspected maltreatment of a child to the local social services agency or law enforcement.

Incident reporting

CFSS provider agencies must establish policies and procedures for responding to incidents that occur while services are being provided. When the participant has a legal representative or a participant's representative, the agency must report incidents to these representatives. When the participant self-directs under the budget model, the participant or the participant's representative must report any adverse incidents to the consultation services provider, FMS provider, case manager or care coordinator, if applicable. Providers of consultation services educates participants and, if applicable, their representatives about how to report adverse incidents and concerns to the appropriate persons. An incident is an occurrence that involves a participant and requires a response that is not a part of the ordinary provision of the services to that participant. Incidents include:

- Serious injury of a participant as defined by state statute
- A participant's death
- Medical emergencies, unexpected serious illness or significant unexpected change in a participant's illness or medical condition that requires a call to 911, physician treatment or hospitalization
- Mental health crises that require a call to 911 or a mental health crisis intervention team
- Acts or situations involving a participant that requires a call to 911, law enforcement or the fire department
- A participant's unexplained absence
- Behavior that creates an imminent risk of harm to the participant or another person
- Reports of alleged or suspected vulnerable adult maltreatment as defined in state statute
- Reports of alleged or suspected maltreatment of minors as defined in state statute

Background study and training requirements

CFSS provider agencies, FMS providers and consultation service providers must comply with background study requirements in accordance with state statute and maintain documentation of background study requests and results. CFSS provider agencies and FMS provider are also required to

comply with background study requirements in accordance with state statute.

All CFSS support workers, regardless of service delivery model, must complete a background study requirement in accordance with state statute before enrolling with DHS as a support worker.

All CFSS support workers are mandated reporters and are required to complete state-provided minimum training components related to identifying and mitigating potential risks to CFSS participants including, but not limited to:

- Basic first aid
- Vulnerable adult and child maltreatment
- Positive behavioral practices
- Responding to a mental health crisis

Provide a description of the conflict of interest standards that apply to all individuals and entities, public or private to ensure that a single entity doesn't provide the assessments of functional need and/or the person-centered service plan development process along with direct CFC service provision to the same individual:

CFSS provides the participant with different types of support from various entities. These entities include the county, tribal human services organization, or managed care organization conducting assessments, CFSS provider agency, consultation services provider, and the FMS provider. While an entity may provide more than one of these supports, a single entity may only provide one type of support to the same CFSS participant. This complies with 42 CFR 441.555.

The participant's representative must not have a financial interest in the provision of any services included in the participant's CFSS service delivery plan. Additional conflict of interest standards for a participant's representative are included in the following section.

☐ Box unchecked: Conflict of Interest Exception: The only willing and qualified entity performing assessments of functional need and or developing the person-centered service plan also provide home and community-based services.

Provide a description, including firewalls, to be implemented within the entity to protect against conflict of interest, such as separation of assessment and/or planning functions from direct service provision functions, and a description of the alternative dispute resolution process:

Standards for assessors (county, tribal human services organization , or managed care organization):

Minnesota law requires all counties and the tribal human services organizations that have elected to administer and manage HCBS program through a DHS contract to provide assessment for eligibility for long-term services and supports. The state contracts with MCOs that serve enrollees age 65 and older to manage home and community-based services and supports for those enrollees.

These entities perform assessments and develop support plans that reflect participant preferences in services and supports for self-direction and include risk management, back-up and emergency planning.

Counties, tribal human services organizations and MCOs are not allowed to enroll as consultation services providers.

A participant's representative may not also be assigned as their county, tribal human services organization, or managed care organization assessor or case manager/care coordinator.

Standards for provider agencies:

The CFSS provider agency supports the participant with many things, including supervising the support worker(s). The CFSS agency model sets conflict of interest standards. The agency staff member providing supervisory duties under the CFSS agency model cannot also be the participant's:

- Family foster care provider
- Direct care (support) worker
- Legal guardian, parent or step-parent when the participant is a minor
- Responsible party
- Spouse

A participant's representative cannot be part of the provider agency's staff unless related to the participant by blood, marriage or adoption.

Standards for consultation services providers:

Consultation services providers assist the participant with planning, developing and implementing the service delivery plan by providing information about service options, choices in providers and rights and responsibilities, including appeal rights.

Consultation services providers can only provide services within the scope of their service. Examples of activities outside of the scope of consultation services include:

- Determining the person's program eligibility
- Supporting the person's appeal of the assessment results
- Performing employer functions for a participant using the budget model or for a CFSS provider agency
- Performing the tasks of a medical provider (e.g., registered nurse, home health aide).

Consultation services providers cannot be the person's FMS provider, county, tribal human services organization, or managed care organization or the CFSS or HCBS waiver vendor or provider agency.

Counties, tribal human services organizations and MCOs are not allowed to enroll as consultation services providers.

A participant's representative may be an employee of the consultation provider, but they cannot be an agency owner or a staff member who delivers consultation services to the participant.

The individual must be informed by the consultation services provider when the provider has any direct or indirect financial interest in the delivery of other services. The consultation services provider must disclose the information to the person in writing. This permits the individual to make an informed choice of whether they wish to select the provider for consultation because it precludes the participant from selecting the provider for other services. The other services the consultation services provide may offer include, but are not limited to:

- CFSS worker training
- Goods
- Any services provided as an MHCP-enrolled provider

The consultation services provider must obtain a document signed by the participant and the consultation services provider stating that:

- The participant acknowledges they understand the information disclosed about the direct or indirect financial interest the provider has in the delivery of other services
- The person identifies they had an informed choice of services, service models and providers and understood the options they had to meet their needs
- The person acknowledges they understand they cannot utilize any other services provided by the Consultation Services provider they have selected
- The consultation services provider offered the participant informed choice of service delivery

Standards for FMS providers:

CFSS provider agency services cannot be provided by the FMS provider.

A participant's representative cannot be the:

- FMS staff, unless related to the participant by blood, marriage or adoption
- FMS owner or manager

Standards for worker training and development:

A participant's representative cannot be the worker training and development service provider.

Assessment of Need

Describe the assessment process or processes the state will use to obtain information concerning the individual's needs, strengths, preferences and goals.

A person interested in receiving CFSS services must receive an assessment of need from a certified assessor. Initial assessments for CFSS are completed when the person requests an assessment from the county, tribal human services organization, or managed care organization that has jurisdiction to complete the assessment, or when another individual requests the assessment on their behalf. The county, tribal human services organization, or managed care organization schedules and conducts the assessment in-person.

The assessment tool is a comprehensive, conversation-based, person-centered assessment. The assessment includes the health, psychological, functional, environmental and social needs of the individual necessary to develop a person-centered support plan that meets the person's needs and preferences.

The assessment tool includes an assessment of ADLs, IADLs, medical service needs, safety and supervision needs and informal caregiver support. The certified assessor also uses information from medical histories, physician records and reports from providers to further evaluate and understand the person’s needs. For children, the assessment also includes identifying needs that are beyond what is typical for a parent. For example, a parent of a minor typically is responsible for grocery shopping, meal preparation, supervision, etc.

Counties, tribal human services organizations, or managed care organizations enter key summary information from the assessment (including information related to the level of care) into MMIS screening documents.

After completion of the assessment, the participant or the participant’s representative develops and evaluates the CFSS service delivery plan through a person-centered planning process, with assistance

from the consultation services provider as desired.

☐ Box checked: The state will allow the use of telemedicine or other information technology medium in lieu of a face-to-face assessment in accordance with the federal code of regulations under §441.535. The individual is provided with the opportunity for an in-person assessment in lieu of one performed via telemedicine. Include a description about how an individual receives appropriate support including access to on-site support staff during the assessment:

The state will claim costs associated with CFC assessment activities as:

☐ Box unchecked: A Medicaid Service

☒ Box checked: An Administrative Activity

Indicate who is responsible for completing the assessment prior to developing the CFC person-centered service plan. Also specify their qualifications:

☐ Box unchecked: Social Worker (specify qualifications)

☐ Box unchecked: Registered Nurse, licensed to practice in the state, acting within scope of practice under state law.

☐ Box unchecked: Licensed Practical Nurse or Vocational Nurse, acting within scope of practice under state law

☐ Box unchecked: Licensed Physician (M.D. or O.D.), acting within scope of practice under state law

☐ Box unchecked: Case Manager (specify qualifications)

☒ Box checked: Other (specify what type of individual and their qualifications)

Assessments are completed by the county, tribal human services organization, or managed care organization that has jurisdiction to complete the assessment for the person. Each county, tribal human services organization, or managed care organization must use assessors who have completed the assessor training and the certification process. Assessors are required to be recertified every three years.

Assessors must meet one of the following requirements:

- Minimum of a bachelor's degree in social work, nursing with a public health nursing certificate or other closely related field with at least one year of home and community-based experience
- Registered nurse with at least two years of home and community-based experience who has received training and certification specific to assessment and consultation for long-term care services in the state.

☒ Box checked: The reassessment process is conducted every: 12 months

☐ Box unchecked: Other (must be in increments of time less than 12 months)

Describe the reassessment process the state will use when there is a significant change in the individual's needs or the individual requests a reassessment. Indicate if this process is conducted in the same manner and by the same entity as the initial assessment process or if different procedures

are followed:

Reassessments are conducted by the county, tribal human services organization, or managed care organization. Reassessments are completed using the same assessment tool that is used for the initial assessment, in the same manner and many times by the same entity as the initial assessment. Up to two remote reassessments may be conducted following an in-person assessment or reassessment.

A different county, tribal human services organization, or managed care organization may complete the reassessment if, during the service plan year, the participant moved to a different region of the state or enrolled in managed care.

Reassessments must be completed at least every 12 months and whenever a significant change in the participant's condition warrants a comprehensive review. Annually, the CFSS provider agency (agency model) or FMS provider (CFSS budget model) requests a reassessment at least 60 days before the end of the service agreement. For participants enrolled in a §1915(c) HCBS waiver or is age 65 or older and enrolled in managed care, the CFSS provider agency or the FMS provider would collaborate the request for reassessment with the participant's case manager or care coordinator.

When a participant has a significant change in condition, the participant, CFSS provider agency (agency model) or FMS provider (budget model) can request a reassessment using the Referral for Reassessment form (PDF). The request for assessment goes to the county, tribal human services organization, or managed care organization who conducts the assessment. After receiving the request, the county, tribal human services organization, or managed care organization will determine if it should complete:

- A 45-day temporary increase in CFSS services
- A full reassessment

Person-Centered Service Plan
The CFC service plan must be developed using a person-centered and person- directed planning process. This process is driven by the individual and includes people chosen by the individual to participate.

The state will claim costs associated with CFC person-centered planning process as:

☒ Box checked: A Medicaid Service

☐ Box unchecked: An Administrative Activity

Indicate who is responsible for completing the Community First Choice person-centered service plan.

☐ Box unchecked: Case Manager. Specify qualifications:

☐ Box unchecked: Social Worker. Specify qualifications:

☐ Box unchecked: Registered Nurse, licensed to practice in the state, acting within scope of practice under state law.

☐ Box unchecked: Licensed Practical Nurse or Vocational Nurse, acting within scope of practice under state law.

☐ Box unchecked: Licensed Physician (M.D. or O.D.), acting within scope of practice under state law.

☒ Box checked: Other. Specify provider type and qualifications: The participant or their representative, with assistance of Consultation Services as requested.

The CFSS service delivery plan is written by the participant and others chosen by the participant, which may include their representative (when applicable) and other people important to support being active in the community and/or meeting the needs described in the plan.

The consultation services provider is a neutral third party who ensures the participant is able to choose who is involved in the development of the CFSS service delivery plan. See provider qualifications under "other" below.

Provider type: Consultation services provider

Qualifications: See the provider qualifications for consultation services providers under the "voluntary training on how to select, manage and dismiss attendants" section of the mandatory services and supports of this document.

Person-Centered Service Plan Development Process: Use the section below to describe the process that is used to develop the person-centered service plan.

Specify the supports and information that are made available to the individual (and/or family or authorized representative, as appropriate) to direct and be actively engaged in the person-centered service plan development process and the individual's authority to determine who is included in the process:

The CFSS service delivery plan is based on the comprehensive assessment, which includes the health, psychological, functional, environmental and social needs of the participant necessary to develop a plan that meets the participant's needs and preferences. The comprehensive assessment is completed by a certified assessor, as described under the assessment section. The participant may choose who is present for the assessment, including their representative, family members and other important people. Service providers may be present to provide care during the assessment and service planning activities, but providers are not included in the assessment process.

The assessor (as defined in Minnesota statute) must determine and communicate the results of the assessment and any recommendations and authorizations for CFSS within 10 business days to the participant or their representative and CFSS providers of choice. After the assessment, the participant chooses a consultation services provider who provides information about CFSS service models, rights and responsibilities (including appeal rights), choice in providers and CFSS policies. The consultation services provider also provides the participant with the CFSS service delivery plan template.

The participant or the representative is responsible to write the CFSS service delivery plan. Consultation services are available to the participant and/or the representative to provide assistance and support in writing the CFSS service delivery plan, to the extent desired by the participant. The participant may choose others to participate in the CFSS service delivery plan development process who are important in supporting them to be active in community and/or meeting the assessed needs. This could include the representative, family members, friends, natural supports or others.

Indicate who develops the person-centered service plan. Identify what individuals, other than the individual receiving services or their authorized representative, are expected to participate in the

person-centered service plan development process. Please explain how the state assures that the individual has the opportunity to include participants of their choice:

The CFSS service delivery plan is written by the participant and others chosen by the participant, which may include their representative (when applicable) and other people important to supporting the participant to be active in the community and/or meeting needs described in the plan.

The consultation services provider is a neutral third party who ensures the participant is able to choose who is involved in the development of the service delivery plan.

The CFSS service delivery plan must be developed and evaluated through a person-centered planning process by the participant or the participant's representative. The consultation services provider can help the participant plan, develop, and implement the service delivery plan by providing information about service options, choice in providers and rights and responsibilities, including appeal rights. The consultation services provider must support the participant in developing the service delivery plan, to the extent the participant desires.

The participant submits the completed service delivery plan to the consultation services provider. The consultation services provider will review the CFSS service delivery plan with the person. In supporting the person, they will review whether the plan meets assessed needs outlined in the needs assessment and contains covered CFSS services. The consultation services provider submits the plan to the State Medicaid agency or the delegate of the State Medicaid Agency for approval. If the participant uses CFSS services on a waiver, the county, tribal human services organization or managed care organization case manager must approve the plan. If the participant is age 65 or older and receives CFSS services through an MCO, the MCO care coordinator must approve the plan. Plan approval includes ensuring the plan meets requirements and does not include services or goods that are not covered.

The approved plan will then be sent by the State Medicaid Agency or delegate to the participant and the CFSS provider agency and/or FMS provider, depending on the service model the person has chosen.

For participants who are using the provider agency model, the CFSS provider agency is responsible to work with the participant to fill in any additional service delivery details not included in the plan.

Describe the timing of the person-centered service plan development to assure the individual has access to services as quickly as possible; describe how and when it is updated, including mechanisms to address changing circumstances and needs or at the request of the individual:

The county, tribal human services organization, or managed care organization's assessor must determine and communicate (in writing) the results of the assessment and any recommendations and authorizations for CFSS within 10 business days to the participant or the representative and chosen CFSS providers. The written communication from the county, tribal human services organization, or managed care organization allows the participant to begin developing the CFSS service delivery plan as soon as possible.

The written communication must include the participant's right to appeal the assessment in accordance with state law. The participant or the representative will complete the CFSS service delivery plan based on the information provided by the county, tribal human services organization, or managed care organization's assessor, with assistance from the consultation service provider, if

requested. The consultation services provider supports the participant in the person-centered planning process.

The participant/representative and consultation services provider review the CFSS service delivery plan at least annually upon reassessment, or more frequently when there is a significant change in the participant's condition, a change in the participant's need for services and supports or if the participant requests a person-centered assessment. When the participant has an assessment that results in a change of the participant's need for services, the consultation services provider will help the participant change the service delivery plan so it aligns with the change in service need.

The county, tribal human services organization, or managed care organization must conduct an assessment within 20 business days of receiving a request when there is a significant change in the participant's condition, a change in the participant's need for services and supports or if the participant requests a person-centered assessment. If the participant has a temporary change in condition that requires more support, the county, tribal human services organization, or managed care organization can conduct a telephone assessment for a temporary increase.

If the participant has an immediate need to begin services, the county, tribal human services organization , or managed care organization can conduct a telephone assessment for a temporary start of services. A participant authorized for a 45-day temporary start does not need to meet with a consultation services provider before they start services. A temporary start is limited to the agency model and direct care services. To continue using CFSS services beyond the 45-day temporary start, the participant must select a consultation services provider, complete an orientation with that provider, select a model and write an approved CFSS service delivery plan before the temporary authorization ends.

Describe the state's expectations regarding the scheduling and location of meetings to accommodate individuals receiving services and how cultural considerations of the individual are reflected in the development of the person-centered service plan:

The person-centered planning process must occur at times and locations convenient to the participant and must reflect the participant's cultural considerations.

All CFSS providers (consultation services, provider agency, etc.) are expected to offer a variety of modes to meet and communicate with the participant or the representative. The modes can include communication via email, text, phone, in-person, video phone or any other mode preferred by the participant. Meetings should be at a location chosen by the participant, with consideration for the participant's preferences for privacy. Meetings must be scheduled flexibly to meet the participant's needs.

DHS requires CFSS providers to develop and implement policies and procedures that emphasize the application and philosophy of participant direction, including being culturally competent in all business practices to communicate effectively with participants of all ages, needs, disabilities and chronic conditions. These expectations also include meeting and communicating with the participant's representative. These expectations are addressed in the planning process.

Describe how the service plan development process ensures that the person-centered service plan addresses the individual's goals, needs (including health care needs), and preferences and offers choices regarding the services and supports they receive and from whom. Please include a description of how the state records in the person-centered service plan the alternative home and

community based settings that were considered by the individual:

After the assessment and completion of a county, tribal human services organization nation, or managed care organization developed support plan that identifies the participant's needs (including health care needs), preferences and goals, the participant chooses a consultation services provider. The consultation services provider:

- Provides orientation regarding the provider agency model and the budget model, including information on roles, responsibilities, processes, policies, options available for services and supports and appeals
- Helps the participant create a plan for the budget under the budget model and, prior to completing the CFSS service delivery plan:
    - Calculates the specific dollar amount
    - Compares the costs of the agency and budget models
    - Describes any limitations associated with the models
- Provides support to the participant (to the extent the participant desires) to develop the plan and ensure the services and supports in the plan match the participant's needs, goals and preferences
- Offers choices to the participant regarding the services and supports to receive and from whom
- Records the alternative HCBS settings the participant considered.

The participant or their representative creates the CFSS service delivery plan using a template developed by DHS or collaborative care plan used by MCOs, which documents:

- People chosen by the participant for support in the planning process and in the provision of services and supports
- The participant's chosen service model and their corresponding choice of provider agency or FMS provider
- HCBS setting options the participant considered and chose
- The participant's strengths, preferences, goals and preferred outcomes
- How the participant's areas of assessed needs will be met, including assistance with ADLs, IADLs, observation and redirection of behavior, health-related needs, or assistance with maintenance, acquisition or enhancement of skills
- Instructions on what support the worker will provide and how the worker will provide it in response to the participant's assessed needs and to achieve the participant's goals and outcomes
- Plans for worker training and development, as applicable
- Risk factors and measures in place to minimize them, including individualized back-up plans
- Individuals or entities responsible for monitoring the service delivery plan

For the budget model, the CFSS service delivery plan must include a detailed spending budget that identifies support worker related expenses and other purchases.

The CFSS service delivery plan must be understandable to the participant and the individuals providing support. When the CFSS service delivery plan is finalized and agreed to in writing by the participant or their representative, the consultation services provider forwards the plan to the State Medicaid agency or their delegate (also referred to as county, tribal human services organization, or managed

care organization) for plan approval. After approval the county, tribal human services organization, or managed care organization then distributes it to the participant and others involved in the CFSS service delivery plan.

Describe the strategies used for resolving conflict or disagreements within the process:

Consultation Services will provide support as desired to the participant to include only covered services in the person-centered service delivery plan. In the event that a participant wishes to include non-covered services in the plan consultation services will provide support to explore alternative solutions to meet the participant's needs with covered goods and services only. In the event that the participant insists on including non-covered goods and services in the person-centered delivery plan and no alternative solutions can be reached the plan will be forwarded to the county, tribal human services organization, or managed care organization for review at which time the county, tribal human services organization, or managed care organization would need to inform the participant of the non-covered items through a formal notice of action. The notice of action will outline the participants appeal rights. This process is described below:

When a budget, good or service is reduced, denied or terminated, the county, tribal human services organization, or managed care organization provides the participant with a Notice of Action (Service Plan) (PDF). The notice of action includes:

- The reason (including the legal basis) for the decision and corresponding action
- Timeline associated with the action
- Information about the appeals process, including how to file an appeal if the participant disagrees with the decision, timelines and the participant's right to request continuation of services during an appeal

Managed care organizations (MCOs) must notify their enrolled members with written notice of denial of payment or the denial, termination or reduction (DTR) of services that the member or the member's health care provider requested. This notice includes:

- The action the MCO is taking
- The reason the MCO is taking this action
- The state and federal laws or MCO policies that support the MCO's action
- The process the member must follow to file an appeal with the MCO or the state

Participants may also submit fair hearing requests if they feel that they have not been offered free choice of service provider.

DHS also tracks patterns in eligibility, service/budget allocation, service delivery plan and termination.

Please describe how the person-centered service plan development process provides for the assignment of responsibilities for the development of the plan and to implement and monitor the plan.

The participant or their representative is responsible to develop the CFSS service delivery plan, with support from the consultation services provider, as desired by the participant. The CFSS service delivery plan reflects the services and supports the participant chooses to meet their assessed needs and identifies the individual or entity responsible for monitoring the CFSS service delivery plan.

When the participant has chosen the provider agency model, the provider agency, participant, and the

representative (when applicable) are responsible for implementing and monitoring the CFSS service delivery plan. The individual(s) or entities responsible for monitoring the plan will be identified on the service delivery plan. The provider agency is responsible for completing an evaluation of CFSS services with 90 days of service initiation and at least quarterly thereafter.

When the participant has chosen the budget model, the participant, the representative (when applicable) and the FMS provider are responsible for implementing and monitoring the CFSS service delivery plan and expenditures. The individual(s) or entities responsible for monitoring the plan will be identified on the service delivery plan.

All service delivery plans are subject to the monitoring of the State Medicaid Agency. For all participants the State Medicaid Agency will audit service delivery plans at the consultation service provider level, review satisfaction surveys and track appeals related to service reduction, termination or denial to identify programmatic deficits. For those who have an assigned case manager or care coordinator, the individual at the County, tribal human services organization, or managed care organization assigned is responsible to ensure the service delivery plan is implemented as outlined. Oversight of service delivery plans is conducted by the state Medicaid agency through the County, tribal human services organization, or managed care organization review process. The county, tribal human services organization, or managed care organization review process is described here:

The State Medicaid Agency conducts on-site county, tribal human services organization, or managed care organization reviews on an ongoing basis. Counties and tribes are randomly selected for review. The purpose of the review is to monitor compliance with program requirements, performance of delegated administrative functions, evaluate how the needs of participants are being met, identify best practices and quality improvement opportunities, and identify areas for technical assistance. Reviews are continuous and ongoing, and all agencies are reviewed at least once every three years. Reviews include a case file review of a randomly selected representative sample of cases.

☒ Box checked: The state assures that assessment and service planning will be conducted according to 441.540(B) 1-12.

The person-centered service plan is reviewed and updated every:

☐ Box unchecked: 3 months

☐ Box unchecked: 6 months

☒ Box checked: 12 months

☐ Box unchecked: Other must be less than 12 months)

AND

☒ Box checked: When an individual's circumstances or needs change significantly or at the individual's request.

Describe the person-centered service plan review process the state will use. In the description please indicate if this process is conducted in the same manner and by the same entity as the initial service plan review process or if different procedures are followed:

The participant and others chosen by the participant are responsible to review the CFSS service delivery plan. The participant may choose to include the representative, when applicable, as well as any other

people important in supporting the participant to be active in the community and/or meeting needs. Other entities that review the CFSS service delivery plan include the case manager or care coordinator (when applicable), consultation service provider and, depending on the service model chosen by the participant, the provider agency or FMS provider.

The CFSS service delivery plan review is conducted in the same manner and by the same entity as the initial CFSS service delivery plan. Different entities may review the CFSS service delivery plan in certain circumstances, including if the participant has chosen a different consultation service provider during the year, changed service models, changed the county of residence or changed the MCO. The CFSS service delivery plan must be reviewed at least annually and whenever the participant has a change in condition.

The consultation services provider will assist the participant with the service delivery plan review and implementing any changes by providing information about how to change the service delivery plan based on the needs identified.

Community First Choice Service Delivery Systems

Identify the service delivery system(s) that will be used for individuals receiving CFC services:

☒ Box checked: Traditional State-Managed Fee-for-Service (4.19(b) page is required)

☒ Box checked: Managed Care Organization; only those serving enrollees age 65 and older

☐ Box unchecked: Other, describe:

Quality Assurance System

Please describe the state's quality improvement strategy:

DHS will review and analyze performance and remediation data (“monitoring data”) according to the following process. Problems or concerns that require intervention beyond the existing remediation processes (i.e., system improvement) will undergo more advanced analysis and new/improved policy and/or procedure development, testing and implementation.

Data sources:

- Input (all identified CFSS program indicator data sources)
- Performance measure and remediation (monitoring) data

Data analysis:

1. Is there a problem (single instance or trend) indicated by the monitoring data?
    - If yes, test data (step 2).
    - If no, return to monitoring.
2. Is the problem real (e.g., not a statistical artifact)?
    - If yes, identify what type of problem is indicated (i.e., policy, process and/or “bad actor”).
    - If no, return to monitoring.
3. Do existing remediation processes address the identified problem?
    - If yes, remediate and return to monitoring.
    - If no, enter the appropriate system improvement realm (i.e., policy or process analysis).

System improvement:

Policy analysis realm

1. Can the problem's cause(s) be identified from analysis of the monitoring data?

- If yes, develop data-driven policy alternatives.
- If no, develop theory-driven policy alternatives.

2. Test policy alternative(s).

3. Select the "best" policy alternative.

4. Enact the new policy and return to monitoring.

Process analysis realm

1. Is the problem an internal (i.e., DHS) or external process issue?

2a. If it is an internal process issue, can the cause(s) be identified from analysis of the monitoring data?

- If yes, develop data-driven internal process alternatives.
- If no, develop theory-driven internal process alternatives.

2b. If it is an external process issue, can the cause(s) be identified from analysis of the monitoring data?

- If yes, develop data-driven external process alternatives.
- If no, develop theory-driven external process alternatives.

3. Test process alternative(s).

4. Select the "best" process alternative.

5. Enact the new process or processes and return to monitoring.

Per the same process outlined above, DHS will monitor and analyze the effects of system design changes and undertake additional system redesign/improvement, as needed. DHS will communicate high-level monitoring and trending data to stakeholders and the public via multiple communication channels.

Describe the methods the state will use to continuously monitor the health and welfare of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports:

DHS seeks to prevent maltreatment through a variety of processes, including:

- CFSS provider background studies
- Support worker certification and background check requirements
- Foundational and participant-centered provider training requirements
- Identification and management of participant health and safety risks through the assessment and support planning process.

The support and CFSS service planning process directs the identification and alignment of services to meet the participant's health and safety needs. An emergency back-up plan ensures a concrete approach to managing unanticipated situations that might otherwise result in maltreatment. An

emergency back-up plan is required as a part of the development of the service delivery plan. It provides specific direction on how to manage general and unplanned staffing emergencies. The consultation services provider is responsible to support the participant or the representative to develop an emergency back-up plan that will ensure the participant's health and safety. Case managers/care coordinators also have an ongoing responsibility to monitor the implementation of CFSS service delivery plans to ensure the participant's health and safety.

The consultation services provider works with the CFSS employer (e.g., CFSS provider agency or participant under the budget model) to ensure the CFSS service delivery plan adequately addresses the health and safety issues and risks identified in the participant's assessment. For participants who use the agency model, CFSS provider agencies monitor service delivery, including the health and safety of participants, on a quarterly basis. If the quarterly monitoring indicates a need for refinement of the participant's CFSS service delivery plan or a need for reassessment, the CFSS agency and/or participant work with the consultation services providers or the county, tribal human services organization, or managed care organization.

The consultation services provider is responsible to ensure support worker training is addressed and support worker performance is documented as required. For participants who use the budget model, the consultation services provider also is responsible to review how the participant's health and safety is managed as a part of their service delivery plan. The consultation services provider supports participants using the budget model in modifying the CFSS service delivery plan and seeking reassessment, as needed.

The consultation services provider is responsible to monitor services on a semi-annual basis for CFSS budget model participants who use a parent of a minor or a spouse as a personal care support worker and do not have a case manager or care coordinator. This monitoring includes ensuring services and/or supports and the service delivery plan are meeting the participant's health and safety needs. The consultation services provider helps the participant make changes to the service delivery plan, as needed.

When a CFSS participant is enrolled in a §1915(c) HCBS waiver or is age 65 or older and enrolled in managed care, the case manager/care coordination has comprehensive monitoring responsibilities. The case manager/care coordinator responds to changes in the participant's health and safety needs, which involves coordinating with the consultation services provider to modify the participant's CFSS service delivery plan, assessing whether other services (e.g., waiver) might help meet the participant's needs or referring the participant for a reassessment.

DHS manages intake and responds to reports of alleged maltreatment of vulnerable adults and alleged maltreatment of children through the state's adult and child protection systems, pursuant to state statute. Maltreatment includes incidents of abuse, neglect or exploitation. State law requires mandated reporters to report suspected maltreatment immediately and encourages all people to report suspected maltreatment. Maltreatment includes, but is not limited to, criminal acts; actions that cause physical pain, injury or emotional distress; adverse or deprivation procedures not authorized under statute; unreasonable confinement; involuntary seclusion; forced separation; failure or omission of a caregiver who has assumed responsibility to provide food, shelter, clothing, health care or supervision; and, for adults, failure by the person to meet their own basic needs and financial exploitation.

Maltreatment reports involving vulnerable adults are made to the Minnesota Adult Abuse Reporting

Center (MAARC), as required in statute. All reports of suspected maltreatment made to the MAARC are forwarded to the lead investigative agency (LIA) or agencies responsible, under statute, for investigation and for protective services. If a report is made initially to law enforcement or an LIA, those agencies are required to take the report and immediately forward it to the MAARC. LIAs include DHS, the Department of Health (MDH) and county social service agencies. Reports alleging a crime are also referred to law enforcement for criminal investigation. The MAARC assesses all maltreatment reports for immediate risk to the vulnerable adult and makes an immediate referral to the county for emergency protective services.

Maltreatment reports involving children are made to the county/tribal social service agency or the police. (Reports involving state-licensed facilities may, but rarely, come directly into the state licensing entity.) The county local welfare agency that receives a maltreatment report is responsible for assessing allegations and providing child protection services. County agencies undertake family assessment or, where they have jurisdiction, investigation activities. When a maltreatment allegation involves a state-licensed facility, the county forwards the maltreatment report to the appropriate state lead investigative entity: Department of Human Services or Department of Health. County lead investigative agencies follow up, to conclusion, on the vast majority of maltreatment reports involving children.

Monitoring Metrics:

Percent of CFSS participant plans reviewed that include an emergency back-up plan during the review period. *Numerator: Number of CFSS participant files that include an emergency back-up plan. Denominator: Number of CFSS participant files reviewed during the current review period.*

Percent of new and existing CFSS support workers that completed training on child protection, maltreatment of vulnerable adults and responsibilities as mandated reporters during the review period*. Numerator: Number of CFSS support workers that completed training on child protection, maltreatment of vulnerable adults and responsibilities as mandated reporters. Denominator: Number of support workers approved to deliver CFSS services during the reporting period.*

Percent of reports involving CFSS Program participants that were submitted to the Minnesota Adult Abuse Reporting Center (MAARC) and then referred to a Lead Investigative Agency (LIA) within two working days. *Numerator: Number of reports involving CFSS Program participants that were submitted to the MAARC and then referred to LIA within two working days. Denominator: Number of reports involving CFSS Program participants that were submitted to MAARC and then referred to LIA.*

Describe how the state measures individual outcomes associated with the receipt of home and community-based attendant services and supports as set forth in the person centered CFSS service delivery plan, particularly for the health and welfare of individuals receiving such services and supports. (These measures must be reported to CMS upon request.)

DHS measures individual outcomes associated with CFSS service delivery plans through participant reports received at reassessment and via participant satisfaction surveys administered by consultation services providers.

The reassessment process includes a discussion between the assessor and participant on progress toward last year's goals, if services are meeting identified needs and whether any service changes are

needed. The consultation services provider uses documentation of that discussion with the participant when developing the CFSS service delivery plan.

Under the agency model, the CFSS provider agency must evaluate services within 90 days of initiation and quarterly thereafter. The provider agency must conduct the first year of quarterly reviews in person. After the first year, DHS requires a minimum of one in-person quarterly review per year. CFSS quarterly evaluations include assessment of whether:

- The participant's CFSS service delivery plan accurately identifies the current service need
- The services are supporting the participant to accomplish goals in the service delivery plan
- The support worker(s) are competent to perform the tasks in the service delivery plan
- The provider agency, participant or participant's representative has any other concerns about the services or service delivery plan

DHS tracks outcomes associated with CFSS services through review and analysis of the data it requires consultation services providers to collect and submit. This includes responses on questions during CFSS service delivery planning sessions with participants, information gathered at required semi-annual reviews and responses from annual participant satisfaction surveys. DHS directs consultation services providers to measure participant satisfaction with the:

- Participant's chosen consultation services provider
- Provision of consultation services information and support
- Participant's CFSS service delivery plan in meeting their assessed needs
- Provision of CFSS services in safeguarding their health and safety
- Provision of CFSS services in helping them meet their service goals

Monitoring Metrics:

Percent of CFSS participants that reported they were satisfied with their CFSS service delivery plan adequately addressing their health and safety needs. *Numerator: Number of CFSS participants that reported their CFSS service delivery plan adequately addressed their health and safety needs. Denominator: Number of participants providing response during the review period.*

Percent of CFSS participants that reported that their CFSS support worker assisted them in meeting their service goals. *Numerator: Number of participants that reported that their CFSS support worker assisted them in meeting their service goals. Denominator: Number of participants providing response during the review period.*

Percent difference between the dollar amount encumbered for CFSS services compared to the dollar amount claimed for CFSS services provided to participants. *Numerator: Dollar amount claimed for CFSS fee-for-service (FFS) services. Denominator: Dollar amount encumbered for CFSS services provided to FFS participants during the review period.*

Describe the standards for all service delivery models for training, appeals for denials and reconsideration procedures for an individual's person-centered CFSS service delivery plan:

Training:

Support workers are required to complete standardized and person-centered training. This training also is available to CFSS participants at a variety of levels, depending on their chosen service model.

Support workers must successfully complete CFSS certification training and the additional training

determined necessary to meet the participant's needs. All CFSS participants must have a worker training and development plan that describes necessary support worker training and the plan for evaluating support worker competency. The support worker's employer (i.e., CFSS provider agency or budget model participant) is responsible to monitor support workers' completion of training and evaluate support workers' competency. The worker training and development plan is updated at reassessment, whenever there is a change in support workers or the service delivery plan or whenever the support worker's performance review reveals a need for additional training.

Consultation services providers offer training to help all participants understand CFSS services, service model options and how to write, implement and evaluate their CFSS service delivery plan. They also help participants acquire skills for interviewing, selecting, managing, evaluating and dismissing support workers. Additionally, consultation services providers offer training to budget model participants to assist in the role as a managing employer, including overseeing the training of support workers.

Support workers provide assistance and training to the participant (as directed by the participant's service delivery plan) that is intended to maximize independence and integration in the community, preserve functioning and defer or eliminate the likelihood of future institutional placement. This includes functional-skills training through hands-on assistance, supervision and cueing to acquire, maintain and/or enhance the skills necessary to accomplish ADLs, IADLs and health-related tasks.

DHS monitors person-centered CFSS participant training and satisfaction. Across both service models, consultation services providers report annually on participant satisfaction with the training and assistance provided to them in developing their CFSS service delivery plan.

Fair Hearings:

DHS requires that CFSS participants receive fair hearing information when they apply for Medicaid, are assessed for services and whenever a service authorization is initiated or modified. Consultation service providers educate and help participants understand their appeal rights related to the CFSS service delivery plan.

When a budget, good or service is reduced, denied or terminated, the county, tribal human services organization, or managed care organization provides the participant with a Notice of Action (Service Plan) (PDF). The notice of action includes:

- The reason (including the legal basis) for the decision and corresponding action
- Timeline associated with the action
- Information about the appeals process, including how to file an appeal if the participant disagrees with the decision, timelines and the participant's right to request continuation of services during an appeal

Managed care organizations (MCOs) must notify their enrolled members with written notice of denial of payment or the denial, termination or reduction (DTR) of services that the member or the member's health care provider requested. This notice includes:

- The action the MCO is taking
- The reason the MCO is taking this action
- The state and federal laws or MCO policies that support the MCO's action
- The process the member must follow to file an appeal with the MCO or the state

Participants may also submit fair hearing requests if they feel that they have not been offered free

choice of service provider.

DHS also tracks patterns in eligibility, service/budget allocation, service delivery plan and termination.

Monitoring Metrics:

Percent completion of support worker training, as directed by the support worker training and development plan of CFSS participants. *Numerator: Number of participants for whom support worker training was completed as directed by the support worker training and development plan of CFSS participants. Denominator: Number of participants for whom training was due to be completed during the review period.*

Percent of CFSS participants who reported they were satisfied with the training/assistance provided by consultation services providers in developing their CFSS service delivery plan. *Numerator: Number of CFSS participants who reported they were satisfied with the training provided by consultation services providers in developing their CFSS service delivery plan. Denominator: Number of CFSS participants providing response during the review period.*

Percent of CFSS fee-for-service (FFS) participants who did not file an appeal that progressed to a hearing before an appeals judge. *Numerator: Number of CFSS FFS participants who did not file an appeal that progressed to a hearing before an appeals judge. Denominator: Number of CFSS FFS participants during the review period.*

Describe the methods used to monitor provider qualifications:

DHS authorizes CFSS services for delivery exclusively by actively enrolled Minnesota Health Care Programs (MHCP) service providers. Approved MHCP CFSS providers must meet and maintain relevant certification, service standards and contract requirements as required by state and federal law.

Support workers must complete a background study and standardized CFSS certification course, including a passing competency test, before they can enroll as an MHCP provider eligible to deliver services. The certification course includes training on first aid, Occupational Safety and Health Administration (OSHA) universal precautions, person-centered planning and self-direction, recognition and reporting of maltreatment and a comprehensive review of support worker roles and responsibilities. MHCP monitors enrolled, qualified support workers on an ongoing basis through monthly review of federal and state provider integrity lists and recertification process whenever the worker changes CFSS provider agencies or FMS provider affiliation.

The support worker's employer (i.e., the CFSS provider agency or the budget model participant) oversees the support worker's training and development plan and evaluates the support worker's competency and performance. CFSS provider agencies must evaluate workers within 30 days of them beginning to deliver services, including shared services. The provider agency verifies and maintains evidence of, minimally annual performance reviews and completed training per the support worker's training and development plan. Consultation services providers assist budget model participants with support worker monitoring and management functions, including the charting of worker performance improvement initiatives and, when needed, assistance with worker discharge.

Consistent with state and federal law, DHS requires all enrolled providers to be screened based on the level of risk of fraud, waste or abuse to the Medicaid (Medical Assistance) program. CFSS provider agencies are classified as providers who are at a "high risk" of perpetrating fraud, waste or abuse.

These providers receive both pre-enrollment and post-enrollment site visits by DHS' Office of Inspector General (OIG) as part the MHCP enrollment screening process. OIG's Surveillance and Integrity Review Section (SIRS) Provider Screening unit conducts pre-enrollment and post-enrollment on-site visits to verify that enrollment information submitted to DHS is accurate and complies with federal and state law. This includes a review of employee qualifications and provider policies and procedures. When program integrity concerns are identified, they are referred to the SIRS Provider Investigations unit.

Consultation Service providers are considered limited risk. These providers are required to respond to a Request for Proposal and execute a contract with DHS. They also undergo the MHCP enrollment screening process to validate all provider requirements have been met in accordance with federal and state law. This includes a review of employee qualifications and provider policies and procedures. When program integrity concerns are identified that cannot be remedied with technical assistance they are referred to the SIRS Provider Investigations unit. Consultation Service provider contracts are subject to audit provisions as outlined in the contracts. Consultation service providers are also audited annually by DHS through the quality assurance measures including systemic review of person-centered service delivery plans and through administration of participant surveys. Contracts are renewed every 5 years or a time period determined by DHS. Revalidation of enrollment occurs every five years. FMS providers must successfully complete a readiness review through an external FMS review vendor before responding to DHS' request for proposal. Once awarded a contract and enrolled as a qualified MHCP provider, the FMS provider receives a site visit conducted by DHS within the first year of service provision. Every three years thereafter, DHS conducts a contract-monitoring desk audit. If the desk audit indicates the provider failed to comply with tasks and deliverables, DHS will develop a corrective action plan and may ultimately require an external review.

DHS maintains a list of active MHCP providers in the Medicaid Management Information System (MMIS) provider subsystem. MMIS system edits ensure that payment is made only to enrolled, active MHCP providers authorized to provide the service(s) for which they have billed. If a provider's certification expires or is revoked or if a provider's contract no longer applies, DHS removes the provider from the MHCP database, unless there is correction of cited deficiencies. DHS rejects claims from providers that are not actively enrolled.

Monitoring Metrics:

Percent of CFSS claims paid to active MHCP providers. *Numerator: Number of CFSS claims paid to active MHCP providers. Denominator: Number of all CFFS claims paid during the review period.*

Percent of CFSS budget model participants served by support workers determined at performance review to perform job functions adequately. *Numerator: Number of budget model participants served by support workers determined at performance review to perform job functions adequately. Denominator: Number of CFSS budget model participants who evaluated support worker performance during the review period.*

Describe the methods for assuring that individuals are given a choice between institutional and community based services:

As part of the assessment process, the support plan and service delivery plan requires the participant or representative to initial a series of statements indicating they understand the available choices. These choices include receiving Medicaid-funded care in an institution, Medicaid-funded community-based services, only non-Medicaid services or no services at all. The assessor presents participants who

meet institutional level of care with a choice of services in the community, including 1915(c) waiver services, or in an institutional setting. The assessor documents the participant's choice of service setting and revisits the participant's choices at least annually, as part of the reassessment process.

Monitoring Metric:

Percent of CFSS participant plans reviewed that document the choice between institutional and community-based services given to participants who meet institutional level of care*. Numerator: Number of CFSS participant plans reviewed that document the participant's choice between institutional and community services. Denominator: Number of CFSS participant plans reviewed during the review period.*

Describe the methods for assuring that individuals are given a choice of services, supports and providers:

A participant assessed as eligible to receive CFSS services and supports receives a list of qualified consultation services providers. From this list, the participant selects the provider who will help to develop a CFSS service delivery plan. The consultation services provider presents the participant with information about and provides guidance in selecting a service model. This includes information about services and supports and the providers qualified to deliver them. The participant receives a list of qualified CFSS provider agencies (if participating in the agency model) and a list of qualified FMS providers (if participating in the budget model or intending to purchase goods in the agency model). In an ongoing capacity, the consultation services provider helps the participant change the service delivery plan, service model and/or service providers as needed.

The consultation services provider is required to document that each participant was offered a choice of service model, CFSS provider agency and FMS provider as relevant to the service delivery plan. As part of completing and approving a CFSS service delivery plan, a certified assessor or case manager/care coordinator confirms and documents that the participant was offered a choice of services, support and providers. DHS' waiver review team monitors compliance with participant choice requirements for participants on a 1915(c) waiver. DHS is able to access the consultation services provider's documentation of participant choice through desk reviews, as specified by contract.

Monitoring Metric:

Percent of CFSS participant plans reviewed that document the participant's choice between/among services and providers. *Numerator: Number of plans reviewed in which participant choice was documented. Denominator: Number of participant plans reviewed during the review period.*

Describe the methods for monitoring that the services and supports provided to each individual are appropriate:

The participant's support plan is a written summary of the needs the assessor identified through the assessment process, aligned to the services and supports the participant selected. DHS monitors the alignment of services and supports to meet the participant's needs identified in the assessment. Participants receive reassessments on an annual basis or whenever there is a change in need that requires a modification to the existing CFSS service delivery plan. DHS monitors the frequency of CFSS participant reassessments and determinations of appeals.

Consultation services providers help CFSS participants develop the person-centered CFSS service

delivery plan. This includes helping the participant make informed choices of service model and service provider. DHS monitors the quality of the assistance CFSS participants receive through participant satisfaction surveys. When it identifies patterns of poor performance, DHS provides technical assistance to the consultation services provider.

CFSS provider agencies monitor the delivery of CFSS services to agency model participants. Agency model participants may request a change in service support worker, provider agency or CFSS service model at any time. Consultation services providers respond to participant requests for assistance and ensure adjustment of the participant's service delivery plan to direct delivery of appropriate services and supports.

Consultation services providers help budget model participants with the ongoing evaluation and management of CFSS services and supports. DHS monitors the effectiveness of the assistance provided to budget model participants in ensuring support worker skill and competency and successful implementation of their CFSS service delivery plan.

DHS monitors participant satisfaction with the CFSS service delivery plan as a key indicator of the adequacy and appropriateness of the services and supports participants receive through the program. When it identifies dissatisfaction, DHS assesses underlying issues and works with the Consultation services provider to address problems as needed.

Monitoring Metrics:

Percent of CFSS participant service delivery plans that document services to address ADL and IADL domains of assessed need. *Numerator: Number of CFSS participant plans that document services to address ADL and IADL domains of assessed need. Denominator: Number of budget model CFSS participant plans reviewed.*

Percent of CFSS participant service delivery plans reviewed that are updated annually. *Numerator: Number of service delivery plans reviewed in which the most recent plan has been updated annually. Denominator: Number of CFSS participants reevaluated during the review period.*

Percent of CFSS participants who reported they were satisfied with their CFSS service delivery plan adequately addressing their needs. *Numerator: Number of CFSS participants who reported satisfaction with their CFSS service delivery plan. Denominator: Number of participants providing response during the review period.*

Describe the state process for ongoing monitoring of compliance with the home and community-based setting requirements, including systemic oversight and individual outcomes:

CFSS is a participant-directed method of selecting and providing services and supports that allows the participant maximum control of services and supports. CFSS services, by their nature, are individualized, provided in the community, the participant's private home or non-disability-specific setting and allow full access to the broader community according to the participant's needs and preferences. Participants choose which services and supports to receive and who provides them.

The CFSS service provider does not own or control the setting. This means:

- The CFSS provider does not have a direct or indirect financial relationship with the property owners in the settings described below. Participants do not need to use a specific CFSS provider in order to live in the residence. Therefore, the nature of the relationship does not

affect the care provided or the financial conditions applicable to tenants.

Although the CFSS provider does not own or control the setting, person-centered planning remains an important protection to ensure participants have opportunities for full access to the greater community, to the same degree as people who do not receive Medicaid HCBS.

DHS will use several strategies at the provider and recipient levels to ensure ongoing compliance with the HCBS requirements and to ensure person-centered practices are at the forefront of CFSS service delivery:

- Support workers complete required person-centered training as part of worker training and development for both the agency and budget models
- Provider agencies complete initial CFSS training that includes person-centered practices, as well as service and protection-related rights
- Consultation service providers offer choices to participants regarding the services and supports to receive and from whom, and they record the alternative HCBS settings the participants considered in the service delivery plans
- Consultation service providers educate participants on CFSS service expectations and person-centered practices and their service and protection-related rights upon initial orientation and annually upon participant request
- DHS surveys participants annually on their experience with CFSS services to ensure person-centered practices are being followed and their rights are asserted and protected
- Provider agencies attest to their compliance with HCBS requirements when they enroll with DHS
- Desk audits of provider attestation
- Site specific review(s) where identified as outlined in settings standard review document and settings crosswalk related to HCBS settings standards.

CFSS Program Monitoring Metrics cited in other quality assurance sections that ensure compliance with HCBS Settings requirements:

- Percent of CFSS participants who reported that they were satisfied with the training/assistance provided by Consultation services providers in developing their service delivery plan
- Percent of CFSS participants who reported that their Consultation services provider informed them adequately of the program's person-centered practices and their service/protection-related rights
- Percent of CFSS participant plans reviewed that document the participant's choice between/among services and providers
- Percent of CFSS participants who reported that they were satisfied with their CFSS service delivery plan adequately addressing their needs
- Percent of CFSS participants who reported that their CFSS support worker assisted them in meeting their service goals
- Percent of CFSS participants who reported that their CFSS support worker adequately safeguarded their service/protection-related rights

Choice and Control

Describe the quality assurance system's methods to (1) maximize consumer independence and control, (2) provide information about the provisions of quality improvement to each individual receiving CFC services and supports:

The state's CFSS quality assurance system provides for the detection and response to deficiency at the individual and system level. A cornerstone of the program is person-centeredness and the positioning of participants to maximize independence and control. DHS ensures attainment of these goals by monitoring the training CFSS participants receive in designing their service delivery plan and the extent of choice they are afforded in selecting their service model and their service provider(s). When a performance issue arises involving a Consultation services provider, DHS provides technical assistance and addresses persistent problems through contract modifications.

DHS also directs monitoring toward identifying the need for system-level improvements (e.g., improved provider training or service standards). The CFSS Implementation Council convenes quarterly to review and assess emerging issues.

Budget model participants exercise ultimate control in overseeing the delivery of CFSS services. Through monitoring the quality of assistance participants receive in assuming the employer responsibilities, DHS ensures that budget model participants are set up for success in achieving optimal outcome, as well as maximum independence. DHS tracks performance trends across Consultation services providers and addresses the need for improvement.

Annually, the assessor and the Consultation services provider explain the participant's ability to ask questions, update goals and/or change the service delivery plan. Case managers/care coordinators have more frequent discussions with participants where they are involved in support planning.

Monitoring Metrics:

Percent of CFSS participants who reported that their Consultation services provider informed them adequately of the program's person-centered practices and their service/protection-related rights. *Numerator: Number of CFSS participants who reported that their Consultation services provider informed them adequately of person-centered practices and their service/protection-related rights. Denominator: Number of CFSS participants providing response during the review period.*

Percent of CFSS participants who reported that their CFSS support worker adequately safeguarded their service/protection-related rights. *Numerator: Number of participants who reported that their CFSS support worker adequately safeguarded their service/protection-related rights. Denominator: Number of participants providing response during the review period.*

Stakeholder Feedback

Describe how the state will elicit feedback from key stakeholders to improve the quality of the community-based attendant services and supports benefit:

The CFSS Development and Implementation Council for CFSS is established in accordance with state statute. As required by statute and federal requirements for Community First Choice (also known as §1915(k)), the council is made up of a majority of people receiving services or family members of people receiving services. The 24-member council comprises:

- Thirteen people receiving services or family members of people receiving services

- Two managed care representatives
- Two county assessors or case managers
- One Individual Education Program (IEP) or school representative
- Two advocate representatives
- Two PCA agency representatives
- Two fiscal support entity or financial management services (FMS) representatives.

Additional membership details can be found on the Office of the Minnesota Secretary of State Board and Commission page.

The CFSS Development and Implementation Council meets quarterly and incorporates stakeholder feedback into its quality improvement strategy in the following ways:

1. DHS requests feedback from all CFSS participants using the annual consultation services survey. This survey collects information about the support planning process and service delivery. DHS uses this information as a key data source in its quality management strategy that was described earlier.
2. DHS convenes quarterly with the CFSS Implementation Council to review participant survey data and trends and other program quality data.
3. DHS makes summary information about the CFSS program available on the program website and fact sheets.
4. DHS holds webinars and community forums to review major program changes that are being considered or implemented.

Identify the stakeholders from whom the state will elicit feedback:

☒ Box checked: The state will elicit feedback from the following stakeholders: (1) Individuals receiving CFC services and if applicable, their representatives, (2) disability organizations, (3) providers, (4) families of elderly individuals or individuals with disabilities, (5) and members of the community.

☐ Box unchecked: Other Describe:

State Assurances

☒ Box checked: The state assures there are necessary safeguards in place to protect the health and welfare of individuals provided services under this state Plan Option, and to assure financial accountability for funds expended for CFC services.

☒ Box checked: With respect to expenditures during the first full year in which the state plan amendment is implemented, the state will maintain or exceed the level of state expenditures for home and community-based attendant services and supports provided under §1905(a), §1915, §1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding year.

☒ Box checked: The state assures the collection and reporting of information, including data regarding how the state provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the state provides individuals with disabilities who otherwise qualify for institutional care under the state plan or under a waiver the choice to instead receive home and community-based services in lieu of institutional care, and the impact of CFC on the physical and emotional health of individuals.

☒ Box checked: The state shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year such services and supports are provided:

(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this option during the fiscal year.
(ii) The number of individuals that received such services and supports during the preceding fiscal year.
(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.
(iv) Whether the specific individuals have been previously served under any other home and community-based services program under the state plan or under a waiver.

☒ Box checked: The state assures that home and community-based attendant services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable federal and state laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- 1148 (CMS-10398 #50). The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(k) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☒	HCBS Personal Care

HCBS Personal Care Assistance

Payment under the agency-provider model with service unit allocation is the lower of the submitted charge, or the state agency established rate, up to the number of units authorized in the participant's approved service allocation:

Personal Care 1:1 unit $5.95

Personal Care 1:2 unit $4.47

Personal Care 1:3 unit $3.92

NOTE: One unit is equal to 15 minutes.

Participants receiving services under the agency-provider model who then transfer to the budget model, will have any remaining service units converted to a service budget as described above.

Shared care:

For two participants sharing services, payment is one and one-half times the payment for serving one participant. For three participants sharing services, payment must not exceed two times the payment for serving one participant. This paragraph applies only to situations in which all participants were present and received shared services on the date for which the service is billed. Rate formulas are as follows:

For 1:2 shared care the formula is: $5.95 multiplied by 1.5 = $8.93 divided by 2 = 4.47

This formula enables us to not exceed the maximum rate of 1.5 times the payment rate for serving one participant.

For 1:3 shared care the formula is: $5.95 multiplied by 1.98 = 11.79 divided by 3 = 3.92

This formula enables us to not exceed the maximum rate of two times the payment rate for serving one participant.

Direct staffing wage costs were the main driver of rates. The rate methodology consisted of:

• A base wage index was established using Minnesota-specific wages taken from job descriptions and standard occupational classification codes from the BLS Occupational Handbook.

• A competitive workforce factor multiplier was applied to the direct staffing wage to address the difference in average wages for direct care staff and other occupations with similar education, training, and experience requirements, as identified by the BLS Occupational Handbook.

• The average wages were adjusted to differentiate between shared and individual staffing.

• Shared staffing was taken into account, when staff are available to provide services to more than 1 person and individual staffing, when direct care staff are available to solely provide support as a 1-to-1 interaction with a specific individual.

• These wage expenses were multiplied by factors for relief staffing, ancillary staff needs, employee-related taxes and benefits, and client programming.

Personal Care Assistance--Budget Model

Under the budget model, an amount equal to the participant's authorized service units multiplied by the amount listed above for a 1:1 unit (@ $5.95), is authorized for use by the participant.

Shared care: For 1:2 and 1:3 shared care under the budget model, services are billed in the shared care formula outlined above.

An enhanced rate of 107.5 percent of the rate paid for CFSS must be paid for services provided to persons who qualify for ten or more hours of CFSS per day when provided by a support worker who meets the training requirements.

HCBS Adult Day Health

HCBS Habilitation

☐	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
X	Other Services (specify below)
	Personal Emergency Response Systems (PERS) Personal emergency response systems include three parts. Each part has its own limit per service agreement year: • Purchase of the PERS equipment, including necessary training or instruction on use of the equipment ($1,500 maximum) • Installation, setup and testing of the PERS equipment ($500 maximum) • Monthly monitoring fees ($110 monthly maximum). The CFSS participant receives up to $3,000 total of personal emergency response equipment and related services per service agreement year.
	Individual Directed Goods and Services When a participant chooses to purchase goods and services through CFSS, the cost for the goods and services is covered using the particpant's service budget. Goods and Services must not exceed an individual's budget allocation.

Financial Management Services

Financial Management Services (FMS) providers must provide their service rates to the state agency as a part of the contracting process. They are required to notify the state agency immediately of any changes to their established rates. FMS providers must make public the maximum rate(s) for their services and a public site with approved providers and rates is maintained by DHS at https://mn.gov/dhs/people-we-serve/people-with-disabilities/services/home-community/programs-and-services/fms.jsp. The rate and scope of FMS is negotiated between the participant or the participant's representative and the FMS provider, and included in the service delivery plan. FMS provider fees must be on a fee-for-service basis other than a percentage of the participants' service budget, and may not include set up fees or base rates or other similar charges.

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L-

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Group VIII Adults

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130724

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L-

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	ABP2a
The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.	Yes

Explain how the state has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements.

In accordance with requirements of 42 CFR 440.330, the state submitted a comparison of the benefits available under this approved plan and the benefits available under a base benchmark plan as described in 45 CFR 156.100. The comparison demonstrated that the benefits under the approved state plan are as robust, if not more robust with regards to amount, duration, and scope, in each of the ten Essential Health Benefit categories as those provided by the base benchmark plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- [ ]

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package ABP3

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: Group VIII Adults

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ◉ Secretary-Approved Coverage.
  - ◉ The state/territory offers benefits based on the approved state plan.
  - ○ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.
    - ◉ The state/territory offers the benefits provided in the approved state plan.
    - ○ Benefits include all those provided in the approved state plan plus additional benefits.
    - ○ Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.
    - ○ The state/territory offers only a partial list of benefits provided in the approved state plan.
    - ○ The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations:

All benefits and applicable limitations are provided as outlined by the Minnesota State Plan under Title XIX of the Social Security Act, Medical Assistance Program in Section 3 - Services: General Provisions and Attachments 3.1-A and 3.1-B.

Selection of Base Benchmark Plan

Alternative Benefit Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- (•) Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ( ) Any of the largest three state employee health benefit plans by enrollment.
- ( ) Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ( ) Largest insured commercial non-Medicaid HMO.

Plan name: Health Partners HLPT - 129123512

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.
The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid state plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130801

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L-

Alternative Benefit Plan Cost-Sharing — ABP4

☑ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. No

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C-

Benefits Description ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

The state/territory is proposing "Secretary-Approved Coverage" as its section 1937 coverage option. Yes

Secretary-Approved Benchmark Package: Benefit by Benefit Comparison Table

The state/territory must provide a benefit by benefit comparison of the benefits in its proposed Secretary-Approved Alternative Benefit Plan with the benefits provided by one of the section 1937 Benchmark Benefit Packages or the standard full Medicaid state plan under Title XIX of the Act. Submit a document indicating which of these benefit packages will be used to make the comparison and include a chart comparing each benefit in the proposed Secretary-Approved benefit package with the same or similar benefit in the comparison benefit package, including any limitations on amount, duration and scope pertaining to the benefits in each benefit package.

An attachment is submitted.

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Health Partners HLPT-129123512

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved

Alternative Benefit Plan

Essential Health Benefit 1: Ambulatory patient services — Collapse All

Benefit Provided: Physicians' Services
Source: State Plan 1905(a) — Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Services provided within the scope of practice as defined under state law.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Some services may require authorization based on criteria consistently applied across all service categories.

Benefit Provided: Outpatient Hospital Services
Source: State Plan 1905(a) — Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Services provided within the scope of practice as defined under state law.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Some services may require authorization based on criteria consistently applied across all service categories.

Benefit Provided: Clinic Services
Source: State Plan 1905(a)
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided:

Chiropractor (OLP)

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services beyond 6 manipulations per month or 24 per year require authorization. One annual evaluation allowed without prior authorization.

Benefit Provided:

Hospice Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Family Planning

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Alternative Benefit Plan

Scope Limit:

Services provided within the scope of practice as defined under state law. Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

Essential Health Benefit 2: Emergency services — Collapse All

Benefit Provided: Emergency Hospital Services (outpatient hospital)

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Medical services required for the immediate diagnosis and treatment of medical conditions that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death or are necessary to alleviate severe pain.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Emergency Transp./Ambulance (outpatient hospital)

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

All air ambulance transportation originating outside of Minnesota or going to a destination outside of Minnesota must receive authorization. Does not include destinations to facilities located in neighboring states when the county of the neighboring state is contiguous to Minnesota.

Add

Alternative Benefit Plan

Essential Health Benefit 3: Hospitalization — Collapse All

Benefit Provided:

Inpatient Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Certain inpatient hospital services, such as certain spinal fusion surgeries, may require authorization because other more appropriate treatments may exist.

Add

Alternative Benefit Plan

Essential Health Benefit 4: Maternity and newborn care — Collapse All

Benefit Provided: Maternity and Postpartum Care (Physician)
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Services provided within the scope of practice as defined under state law.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Delivery and Inpatient Care (Inpatient Hospital)
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Services provided within the scope of practice as defined under state law.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

Essential Health Benefit 5: Mental health and substance use disorder services including behavioral health treatment

Collapse All

Benefit Provided: Medication Therapy Management (OLP)

Source: State Plan 1905(a)

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The service is available to all outpatient recipients not eligible for Medicare Part D who are taking three or more prescriptions to treat or prevent one or more chronic conditions. Follow-up encounters in excess of coverage thresholds may be authorized.

Benefit Provided: Mental Health Outpatient Services - Rehab

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some services may require authorization based on criteria consistently applied across all service categories.

Benefit Provided: Mental Health Inpatient Services - Rehab

Source: State Plan 1905(a)

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

Services provided within the scope of practice as defined under state law.

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Certain services, such as Intensive Residential Treatment Services (IRTS), require authorization to provide services in excess of thresholds. Providers must seek authorization to provide services beyond 90 days. Services are not provided in an IMD.

Benefit Provided:

Substance Abuse Outpatient Services - Rehab

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some services may require authorization based on criteria consistently applied across all service categories.

Benefit Provided:

Substance Abuse Residential Services - Rehab

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Residential substance abuse services must be authorized via an assessment of medical necessity. Services are not provided in an IMD.

Add

Alternative Benefit Plan

Essential Health Benefit 6: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☒ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The State of Minnesota's Alternative Benefit Plan prescription drug benefit is the same as under the approved Medicaid state plan for prescribed drugs.

Alternative Benefit Plan

Essential Health Benefit 7: Rehabilitative and habilitative services and devices — Collapse All

Benefit Provided: Home Health Services
Source: State Plan 1905(a)
Remove

Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Services provided within the scope of practice as defined under state law.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Services include home health aide and skilled nurse visits which require authorization based on assessed need.

Benefit Provided: Medical Supplies and Equipment (Home Health)
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Services provided within the scope of practice as defined under state law.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Certain items such as diabetic supplies may require authorization when usage exceeds thresholds. Other items, such as a needle-free injection device may require prior authorization.

Benefit Provided: Physical Therapy
Source: State Plan 1905(a)

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Rehabilitative and habilitative services are provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services require prior authorization and authorization for continued services every 60 days.

Remove

Benefit Provided:

Occupational Therapy

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Rehabilitative and habilitative services are provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services require prior authorization and authorization for continued services every 60 days.

Benefit Provided:

Speech, Language, & Hearing Therapy

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Rehabilitative and habilitative services are provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Speech language therapy requires prior authorization and authorization for continued services every 60 days. Certain audiology services require authorization to provide services in excess of service thresholds.

Benefit Provided:

Nursing Facility

Source:

State Plan 1905(a)

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Alternative Benefit Plan

Scope Limit:

Services provided within the scope of practice as defined under state law for rehabilitative stays.

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Department authorization based on assessed need is required for all nursing facility admissions.

Add

Alternative Benefit Plan

Essential Health Benefit 8: Laboratory services — Collapse All

Benefit Provided: Lab and X-ray Services

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Certain services such as genetic mutation testing for breast and ovarian cancer susceptibility may require authorization.

Add

Alternative Benefit Plan

Essential Health Benefit 9: Preventive and wellness services and chronic disease management — Collapse All

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:	Source:	
Preventive services	State Plan 1905(a)	Remove

Authorization:	Provider Qualifications:
None	Medicaid State Plan
Amount Limit:	**Duration Limit:**
None	None

Scope Limit:

Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Covered services include:"A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/ project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Add

Alternative Benefit Plan

Essential Health Benefit 10: Pediatric services including oral and vision care — Collapse All

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Services provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

Other Covered Benefits from Base Benchmark

Collapse All

Alternative Benefit Plan

☒ Base Benchmark Benefits Not Covered due to Substitution or Duplication — Collapse All ☐

Base Benchmark Benefit that was Substituted: Primary Care Visit - duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Primary care visits are mapped to the ambulatory patient services EHB category. The services are a duplication of physician and clinic services from the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted: Specialist Visit - duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Specialist visits are mapped to the ambulatory patient services EHB category. The services are a duplication of physician and clinic services from the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted: Outpatient Surgery - duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Outpatient surgery services are mapped to the ambulatory patient services EHB category. The services are a duplication of physician, outpatient hospital, and clinic services from the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted: Urgent Care Visit - duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Urgent care visits are mapped to the ambulatory patient services EHB category. The services are a duplication of physician and clinic services from the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted: Weight Loss Programs - duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Weight loss programs are mapped to the ambulatory patient services EHB category. The services are a duplication of physician and clinic services from the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted: Port Wine Stain Removal - duplication
Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Port wine stain removal services are mapped to the ambulatory patient services EHB category. The services are a duplication of physician and clinic services from the approved Medicaid state plan.

Remove

Base Benchmark Benefit that was Substituted:

Other Practitioner Office Visit - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Other practitioner office visits are mapped to the ambulatory patient services EHB category. The services are a duplication of physician and clinic services from the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted:

Inpatient Physician and Surgical - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Inpatient physician and surgical services are mapped to the hospitalization services EHB category. The services are a duplication of inpatient hospital services from the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted:

Maternity and Postpartum Care - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Maternity and postpartum care are mapped to the maternity and newborn care services EHB category. The services are a duplication of physician services from the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted:

Mental/Behavioral Health Outpatient - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Mental/behavioral health outpatient services were mapped to the mental health and substance use disorder services including behavioral health treatment EHB category. The services are a duplication of outpatient mental/behaioral health services provided under the rehabilitative services benefit in the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted:

Substance Abuse Disorder Residential - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substance abuse disorder residential services are mapped to the mental health and substance use disorder services including behavioral health treatment EHB category. The services are a duplication of residential substance use disorder services provided under the rehabilitative services benefit in the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted:

Habilitation Services - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Habilitation services are mapped to the rehabilitative and habilitative services and devices EHB category. The service is a duplication of physical therapy, occupational therapy, and speech, language and hearing therapy services from the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted:

Mental/Behavioral Health Residential - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Residential Mental/behavioral health services are mapped to the mental health and substance use disorder services including behavioral health treatment EHB category. The services are a duplication of residential and outpatient mental/behavioral health services provided under the rehabilitative services benefit in the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted:

Substance Abuse Disorder Outpatient - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Outpatient substance abuse disorder outpatient services are mapped to the mental health and substance use disorder services including behavioral health treatment EHB category. The services are a duplication of substance use disorder services provided under the rehabilitative services benefit in the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted:

Hearing Aids - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Hearing aid services were mapped to the rehabilitative and habilitative services and devices EHB category. The service is a duplication of durable medical supplies and equipment provided under the home health benefit in the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted:

Diagnostic Testing - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Diagnostic testing services were bundled with imaging services and mapped to the laboratory services EHB category. The bundled services are a duplication of lab and x-ray services from the approved Medicaid state plan.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Imaging - duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Diagnostic testing services were bundled with imaging services and mapped to the laboratory services EHB category. The bundled services are a duplication of lab and x-ray services from the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted: Health Education - duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Health education services are mapped to the preventive and wellness services and chronic disease management EHB category. The services are a duplication of preventive health services provided under the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted: Emergency Trans. / Ambulance - duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Emergency transportation and ambulance services services are mapped to the emergency services EHB category. The services are a duplication of outpatient hospital services from the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted: Preventive Care - duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Preventive care, screenings, and immunization services are mapped to the preventive and wellness services and chronic disease management EHB category. The services are a duplication of preventive services from the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted: Hospice Services - duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Hospice services are mapped to the ambulatory services EHB category. The services are a duplication of hospice services from the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted: Family Planning Services - duplication

Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Family planning services are mapped to the ambulatory services EHB category. The services are a duplication of family planning services from the approved Medicaid state plan.

Remove

Base Benchmark Benefit that was Substituted:

Home Health Care Services - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Home health care services are mapped to the rehabilitative and habilitative services and devices EHB category. The services are a duplication of home health services from the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted:

Emergency Hospital Services - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Emergency hospital services services are mapped to the emergency services EHB category. The services are a duplication of outpatient hospital services from the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted:

Chiropractor - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Chiropractor services are mapped to the ambulatory services EHB category. The services are a duplication of chiropractor services from the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted:

Medication Management - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Medication management services were mapped to the mental health and substance use disorder services including behavioral health treatment EHB category. The service is a duplication of medication therapy management (OLP) services from the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted:

Durable Medical Equipment - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Durable medical equipment is mapped to the rehabilitative and habilitative services and devices EHB category. The services are a duplication of the home health medical supplies, equipment and supplies benefit in the approved Medicaid state plan.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:

Delivery and Inpatient Care - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Delivery and inpatient care is mapped to the maternity and newborn care EHB category. The services are a duplication of the inpatient hospital services benefit in the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted:

Prescription Drugs - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Prescription drugs are mapped to the prescription drugs EHB category. The services are a duplication of the prescribed drugs benefit in the approved Medicaid state plan.

Base Benchmark Benefit that was Substituted:

Nursing Facility - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Nursing facility rehabilitation stay benefits are mapped to the rehabilitative and habilitative services and devices EHB category. The services are a duplication of the nursing facilities benefit in the approved state plan.

Add

Alternative Benefit Plan

☒ Other Base Benchmark Benefits Not Covered

Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Routine Eye Exam (Adult)

Source:

Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

Routine eye exams for adults is excluded from the EHB under 45 CFR 156.115(d).

Add

Alternative Benefit Plan

☒ Other 1937 Covered Benefits that are not Essential Health Benefits — Collapse All ☐

Other 1937 Benefit Provided: Adult Dental

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: No

Duration Limit: None

Scope Limit: Adult dental services are generally limited to the prevention and amelioration of dental disease states.

Other: Certain services, such as bite wing x-rays, require authorization to provide services in excess of thresholds. Providers must seek authorization to provide bite wing x-rays in excess of one series per calendar year.

Other 1937 Benefit Provided: ICF/IID Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other: Department authorization based on assessed need is required for all ICF/IID services.

Other 1937 Benefit Provided: Podiatrist Services (OLP)

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other:

Debridement or reduction of pathological toenails and of infected or eczematized corns or calluses is limited to once every 60 days without authorization.

Remove

Other 1937 Benefit Provided:

Freestanding Birth Centers

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services provided within the scope of practice as defined under state law.

Other:

No authorization requirements.

Other 1937 Benefit Provided:

Mental Health Targeted Case Management

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services provided within the scope of practice as defined under state law.

Other:

Recipients must be diagnosed with severe and persistent mental illness, be referred for services by a medical professional or other interested party, and be determined eligible every 36 months by a county or tribal entity.

Other 1937 Benefit Provided:

Private Duty Nursing

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services provided within the scope of practice as defined under state law.

Remove

Other:

Department authorization based on assessed need is required for all private duty nursing services.

Other 1937 Benefit Provided:

Personal Care Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Yes

Duration Limit:

No

Scope Limit:

Services provided within the scope of practice as defined under state law.

Other:

Department authorization based on assessed need is required for all personal care attendant services.

Other 1937 Benefit Provided:

Nursing Facility Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services provided within the scope of practice as defined under state law for long term stays.

Other:

Department authorization based on assessed need is required for all nursing facility admissions.

Other 1937 Benefit Provided:

Dentures

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit: None

Duration Limit: None

Remove

Scope Limit: Services provided within the scope of practice as defined under state law.

Other: Initial placement or replacement of removable dentures is limited to one time every six years for a recipient unless the dentures are misplaced, stolen or damaged due to circumstances beyond the recipient's control, or the dentures cannot be modified or altered to meet the client's dental needs.

Other 1937 Benefit Provided: FQHC/RHC Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other: Some services may require authorization based on criteria consistently applied across all service categories and applicable to all providers of similar services.

Other 1937 Benefit Provided: Routine Eye Exam (Adult)

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services provided within the scope of practice as defined under state law.

Other: No authorization requirements.

Other 1937 Benefit Provided: Acupuncture Services (OLP)

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Remove

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services provided within the scope of practice as defined under state law.

Other:

Acupuncture services in excess of 40 units requires authorization.

Other 1937 Benefit Provided:

Nurse Midwife

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services provided within the scope of practice as defined under state law.

Other:

No authorization requirements.

Other 1937 Benefit Provided:

Eyeglasses

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services provided within the scope of practice as defined under state law.

Other:

Certain vision therapies require authorization.

Other 1937 Benefit Provided:

Child Welfare TCM

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services provided within the scope of practice as defined under state law.

Other:

Child welfare targeted case management services are available to individuals under the age of 21 with an assessed need.

Other 1937 Benefit Provided:

Relocation Service Coordination TCM

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services provided within the scope of practice as defined under state law.

Other:

Relocation coordination services are provided to recipients residing in inpatient hospitals, nursing facilities, and intermediate care facilities for persons with intelectual disabilities (ICF/IID) who choose to move from an institution to the community.

Other 1937 Benefit Provided:

Vulnerable Adult TCM

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services provided within the scope of practice as defined under state law.

Other:

Targeted case management services are provided to certain vulnerable adults not receiving services through

Alternative Benefit Plan

a home and community based services waiver.

Remove

Other 1937 Benefit Provided:

Behavioral Health Home Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services provided within the scope of practice as defined under state law.

Other:

No authorization requirements.

Add

Alternative Benefit Plan

Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130808

Alternative Benefit Plan

Attachment 3.1-L-

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

- [x] The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).
- [x] The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

  Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

  - (•) Through an Alternative Benefit Plan.
  - ( ) Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

Services to individuals under age 21, including all EPSDT services, will be provided in accordance with the state's approved Medicaid state plan.

Prescription Drug Coverage Assurances

- [x] The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.
- [x] The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.
- [x] The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.
- [x] The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

- [x] The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.
- [x] The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.
- [x] The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

Alternative Benefit Plan

- [x] The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

- [x] The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

- [x] The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

- [x] The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.

- [x] The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

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V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

☒ Managed care.

- ☒ Managed Care Organizations (MCO).
- ☐ Prepaid Inpatient Health Plans (PIHP).
- ☐ Prepaid Ambulatory Health Plans (PAHP).
- ☐ Primary Care Case Management (PCCM).

☒ Fee-for-service.

☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

☑ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

See approved Section 1932(a) pages in Attachment 3.1-F for a description of the implementation plan.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

- ○ Section 1915(a) voluntary managed care program.
- ○ Section 1915(b) managed care waiver.
- ◉ Section 1932(a) mandatory managed care state plan amendment.
- ○ Section 1115 demonstration.
- ○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: Mar 26, 2012

Alternative Benefit Plan

Describe program below:

Beneficiaries will receive coverage through a managed care organization as described in the state's approved Medicaid state plan. American Indians as defined in 25 U.S.C. 1603(c) will receive coverage through a managed care organization as described in the state's MSC+ waiver approved on December 22, 2015.

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

(●) Traditional state-managed fee-for-service

( ) Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

Payments will be made in compliance with the state's approved Medicaid state plan. Existing managed care service carve outs for child welfare targeted case management, targeted case management for vulnerable/developmentally disabled adults, relocation service coordination, ICF-DD services, nursing home services, abortion services, and services identified in an enrollee's individual education plan (IEP) will carry over and be reimbursed fee for service. During the 30 day managed care selection period, individuals will receive coverage via a fee for service delivery system.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

PRA Disclosure Statement

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V.20130718

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L-

Employer Sponsored Insurance and Payment of Premiums — ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package. Yes

Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:

The state's cost effective health insurance reimbursement program, that includes employer sponsored insurance, authorized under Section 1906 of the Act is described in Attachment 4.22-C of the approved state plan. The cost effective insurance program applies to all state plan eligibility groups.

The state/territory otherwise provides for payment of premiums. Yes

Provide a description including the population covered, the amount of premium assistance by population, required contributions, cost-effectiveness test requirements, and benefits information.

For a Medicaid beneficiary who receives coverage in a health plan in the individual market through the state's approved Medicaid state plan that provides premium assistance under section 1905(a) and regulations codified at 42 CFR §435.1015, the state assures that the Medicaid beneficiary will receive all benefits for which the individual is covered under the State plan that are not available through the individual health plan. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

PRA Disclosure Statement

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Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L-

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

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V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L-

Payment Methodology — ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: MINNESOTA

COORDINATION OF TITLE XIX WITH PART A AND PART B OF TITLE XVIII

The following method is used to provide benefits under Part A and Part B of Title XVIII to the groups of Medicare-eligible individuals indicated:

A. Part B buy-in agreements with the Secretary of HHS. This agreement covers:

1. x Individuals receiving SSI under Title XVI or State supplementation, who are categorically needy under the State's approved Title XIX plan.

   Persons receiving benefits under Title II of the Act or under the Railroad Retirement System are included:

   Yes _ No x

2. x Individuals receiving SSI under Title XVI, State supplementation, or a money payment under the State's approved Title IV-A plan, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under Title II of the Act or under the Railroad Retirement System are included:

   Yes _ No x

3. _ All individuals eligible under the State's approved Title XIX plan.

4. x Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

5. x Specified Low-Income Medicare beneficiaries provided by §1902(a)(10)(E)(iii) and §1905(p)(3)(A)(ii) of Title XIX

6. x Qualifying Individuals provided by §1902(a)(10)(E)(iv)(I) and §1905(p)(3)(A)(ii).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: MINNESOTA

COORDINATION OF TITLE XIX WITH PART A AND PART B OF TITLE XVIII

B. Part A group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

1. Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

2. Qualified Disabled and Working Individuals provided by §1902(a)(10)(E)(ii), §1905(s) and §1905(p)(3)(A)(i) of Title XIX.

C. Payment of Part A and Part B deductible and coninsurance costs. Such payments are made on behalf of the following groups:

1. Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

2. Medicaid recipients who are eligible for Title XVIII Part B services.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: MINNESOTA

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation
42 CFR 431.15
AT-79-29

4.1 Methods of Administration

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

Citation		
42 CFR 431.202 AT-79-29 TN-9-80-34	4.2	Hearings for Applicants and Recipients The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.
§1932(a)(5) 42 CFR 431.200(b)		The Medicaid agency has a system of hearings if a MCO takes action that meets all the requirements of 42 CFR Part 438, Subpart F.

Revision: HCFA-AT-87-9 (BERC) OMB No.: 0938-0193
AUGUST 1987

State/Territory: MINNESOTA

Citation	4.3 Safeguarding Information on Applicants and Recipients
42 CFR 431.301 AT-79-29	Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.
52 FR 5967	All other requirements of 42 CFR Part 431, Subpart F are met.

Revision: HCFA-PM-87-4 (BERC)
March 1987

OMB No: 0938-0193

State: Minnesota

Citation **4.4** **Medicaid Eligibility Quality Control**

42 CFR 431.800(a)
50 FR 21839
1903(u)(1)(D) of the Act
P.L. 99-509, sec. 9407

(a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.

(b) The State operates a claims processing assessment system that meets the requirements of 42 CFR 431.830 – 431.836.

___ Yes.
_X_ Not applicable. The State has an approved Medicaid Management information System (MMIS).

42 CFR §431.806
& §431.812(f)
P.L. 111-3, sec. 601(e)(c)

(c) In the State's PERM year, the State adopts the MEQC universe under 42 CFR §431.814 to meet its MEQC review requirement. The State further elects to meets this requirement by substituting for MEQC data the random sampling, eligibility review findings and payment review findings obtained through PERM reviews conducted in accordance with 42 CFR 431.978 through 431.988.

_X_ Effective for FFY 2012

___ Effective for FFY 2015

___ Effective for FFY 2018

In non-PERM years the state will operate MEQC pilots.

Revision: HCFA-PM-99-10 (BERC)
September 1988

State/Territory: MINNESOTA

Citation	4.5	Medicaid Agency Fraud Detection And Investigation Program
42 CFR 455.12; 1902(a)64; AT-78-90; 48 FR 3742; 52 FR 48817		The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR §455.13 through § 455.21 and 42 CFR §455.23 for prevention and control of program fraud and abuse. Minnesota's process for receiving and compiling data concerning alleged and actual instances of fraud, waste, and abuse is as follows: 1. Reports from recipients – Each Medicaid recipient receives an Explanation of Medical Benefits (EOMB), which contains the telephone number of the Department's Recipient Help Desk. ~~If a call~~ When the Department is contacted, all information is forwarded to ~~the Department's Surveillance and Integrity Review (SIRS) Unit~~ the Department's Financial Fraud and Abuse Investigation Division (FFAID). ~~The SIRS unit~~ FFAID determines whether ~~confirms that the caller is a Medicaid recipient and if~~ further investigation is warranted: A. Recipient eligibility fraud: ~~The SIRS Unit assigns the case to the Department's Program Assessment and Integrity (PAI) unit.~~ FFAID coordinates and administers the Fraud Prevention Investigation program.~~This unit~~ FFAID supervises the work of county fraud prevention investigators, who work closely with county eligibility determination staff (financial workers). ~~The PAI Unit~~ FFAID may also investigate eligibility fraud from reports received from county financial workers, from the fraud hot line (posted in each county public assistance office and listed in Medicaid brochures), or from law enforcement. (~~The unit compiles data using a computer-based reporting system.~~

Revision: HCFA-PM-99-10 (BERC)
September 1988

State/Territory: MINNESOTA

Citation	4.5	Medicaid Agency Fraud Detection And Investigation Program
42 CFR 455.12; 1902(a)64; AT-78-90; 48 FR 3742; 52 FR 48817		B. Provider fraud: ~~The~~ FFAID's Surveillance and Integrity Review Section (SIRS) ~~Unit~~ investigates and, if necessary, refers the case to the Minnesota Attorney General's Office. ~~The~~ SIRS ~~Unit~~ keeps a log of each ~~call and all information received~~ fraud report received. 2. Reports from providers – The Department's Minnesota Health Care Programs Provider Manual informs providers that suspected fraud and abuse should be reported to ~~the~~ SIRS ~~Unit~~. Additionally, providers are instructed to contact FFAID's Minnesota Restricted Recipient Program ~~the Department's Primary Care Utilization Review Program with~~ regarding suspected or actual ~~misutilization~~ misuse of services or drugs.

State ___Minnesota

4.5 Medicaid Recovery Audit Contractor Program

Citation	
Section 1902(a)(42)(B)(i) of the Social Security Act 42 C.F.R § 455.516 ~~42 CFR 455.508(b)~~ ~~42 CFR 455.508(f)~~ 42 CFR 455.510 Section 1902(a)(42)(B)(ii)(I) of the Act	_____The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan. _X___ The State is seeking an exception to establishing such program for the following reasons: ~~Pursuant to 42 C.F.R. § 455.516, the Department seeks an exception to 42 C.F.R. § 455.502(b), which requires contracting with a RAC. The Department's RAC contract expired on December 31, 2017, and the Department has been unable to procure a new vendor. The Department published a request for proposals in August, 2016 and then again in November, 2017. We received no proposals in response to the two separate requests. The lack of responses is likely due to the high utilization of managed care in Minnesota (approximately 80%), which reduces the potential revenue for contractors. The Department requests an exception to the RAC requirements for a period of two years, through December 31, 2019.~~ ~~During this time, the Department will utilize its unified program integrity contractor and medical necessity review contractor to identify and audit aberrant claims. This work is in addition to the ongoing monitoring performed by the Surveillance and Integrity Review Section (SIRS) investigation teams.~~ Minnesota requests an exception to the requirement that the RAC must hire a minimum of 1.0 FTE medical director in good standing with the state licensing authorities. Minnesota's RAC will employ a .5 FTE medical director to support Minnesota's RAC work. The medical director is a physician licensed in good standing in several states, and will seek licensure in Minnesota. Minnesota requests an exception to the current three year claims look back period. Minnesota seeks to examine claims for up to five years from the date of the claim in accordance with current State post-payment review and recovery practices.
Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act	_____The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute. Place a check mark to provide assurance of the following: ____ The State will make payments to the RAC(s) only from amounts recovered. _X__ The State will make payments to the RAC(s) on a contingent basis for collection overpayments and identifying underpayments.

	The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee): __x_ The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register. 1. No contingency fee will be paid to a RAC contractor for recoveries from providers who self-disclose. 2. No contingency fee will be paid when no recovery is made for an identified overpayment. __ __ The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.
Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act	_____ The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.
Section 1902 (a)(42)(B)(ii)(III) of the Act	_x___ The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee): A negotiated percentage of the contingency fee, but no more than the highest rate paid to Medicare RACs.
Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act	**_x___** The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).
Section 1902(a)(42)(B)(ii)(IV(bb) of the Act	_x___ The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.
Section 1902 (a)(42)(B)(ii)(IV)(cc) Of the Act	_x___ The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share. _x___ Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

Citation
42 CFR 431.16
AT-79-29

4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State MINNESOTA

Citation
42 CFR 431.17
AT-79-29

4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

Citation
42 CFR 431.18 (b)
AT-79-29

4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

Citation
42 CFR 433.37
AT-78-90

4.9 Reporting Provider Payments to Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

Revision: HCFA-PM-99-3 (CMSO)
JUNE 1999

State: MINNESOTA

Citation 4.10 Free Choice of Providers

42 CFR 431.51
AT-78-90
46 FR 48524
48 FR 23212
§1902(a)(23) of the Act; P.L. 100-93 (§8(f)); P.L. 100-203 (§4113)

(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis. Providers who elect not to provide services based on a history of bad debt, ~~including~~ excluding unpaid co-payments, shall give recipients advance notice and a reasonable opportunity for payment. Recipients retain the ability to seek services from other enrolled providers.

(b) Paragraph (a) does not apply to services furnished to an individual –

(1) Under an exception allowed under 42 CFR §431.54, subject to the limitations in paragraph (c), or

(2) Under a waiver approved under 42 CFR §431.55, subject to the limitations in paragraph (c), or

(3) By an individual or entity excluded from participation in accordance with §1902(p) of the Act, or

§1902(a)(23) of the Act; P.L. 105-33 (§4724(d)(2))

(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services.

Section 1902(a)(23) of the Act; 42 CFR 431.51(a)(6)

(5) Under an exception allowed under 42 CFR §438.50 or 42 CFR §440.168, subject to the limitations in paragraph (c).

State: MINNESOTA

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in §1915(b)(1), a ~~health maintenance organization~~ MCO, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under §1905(a)(4)(C).

Citation

42 CFR 431.610
AT-78-90, AT-80-34

4.11 Relations with Standard-Setting and Survey Agencies

(a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of religious nonmedical health care institutions) that provide services to Medicaid recipients. This agency is: MINNESOTA DEPARTMENT OF HEALTH.

(b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are): MINNESOTA DEPARTMENT OF HUMAN SERVICES.

(c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the ~~Health Care Financing Administration~~ Centers for Medicare & Medicaid Services on request.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: MINNESOTA

Citation
42 CFR 431.610
AT-78-90
AT-89-34

(d) The MINNESOTA DEPARTMENT OF HEALTH (agency) which is the State agency responsible for licensing health institutions, determines for the Minnesota Department of Human Services if institutions and agencies met the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f), and (g) are met.

(e) The State agency designated in item (a) makes recommendations regarding the effective dates of provider agreements, as determined under 42 CFR 431.108.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

Citation
42 CFR 431.105 (b)
AT-78-90

4.12 Consultation to Medical Facilities

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105 (b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105 (b).

☒ Yes, as listed below:

Any facility requesting such services.

☐ Not applicable. Similar services are not provided to other types of medical facilities.

TN # 73-33
Supersedes
TN #

Approval Date 9-3-74 Effective Date 9-3-74

State/Territory: MINNESOTA

Citation		
	4.13	Required Provider Agreement
		With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:
42 CFR 431.107	(a)	For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.
42 CFR Part 483, 1919 of the Act	(b)	For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.
42 CFR Part 483, Subpart ~~B~~ I	(c)	For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart I are also met.
Section 1920 of the Act	(d)	For each provider that is eligible under the plan to furnish ambulatory prenatal care for pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.
		x Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.
	(e)	A provider must meet any standards established, and obtain any licensure required, under state law or rules for the applicable type of health care provider or entity, with the following exception: A provider includes a person who is credentialed as a health professional under standards set by the governing body of a federally recognized Indian tribe and who provides services to recipients through an Indian Health Service facility, which includes an Indian Health Service facility owned or operated by a tribe or tribal organization. All providers must meet the minimum standards in 42 CFR §§440 and 441.

Revision: HCFA-PM-91-9 (MB)
October 1992

OMB No.:

State/Territory: MINNESOTA

Citation
1902(a)(58)
1902(w)

4.13 (e) For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, ~~health maintenance organizations~~ and MCOs~~, and health insuring organizations~~ are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the providers or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State law (whether statutory or recognized by the court(s) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Revision: HCFA-PM-91-9 (MB)
October 1991

OMB No.:

State/Territory MINNESOTA

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient;

(b) Nursing facilities when the individual is admitted as a resident;

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time on initial receipt of hospice care by the individual from the program; and

(e) ~~Health maintenance organizations~~ MCOs at the time of enrollment of the individual with the organization.

(3) ATTACHMENT 4.34-A describes law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives.

___ Not applicable. No State law or court decision exists regarding advance directives.

Revision: HCFA-PM-91-10 (MB)
DECEMBER 1991

State/Territory: MINNESOTA

Citation

4.14 Utilization/Quality Control

~~42 CFR 431.60~~
42 CFR 456.2
50 FR 15312
~~1902(a)(30)(C) and~~
1902(d) of the Act,
P.L. 99-509
(Section 9431)

(a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

X Directly

___ By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control ~~Peer Review Organization (PRO)~~ Quality Improvement Organization (QIO) designated under 42 CFR Part 462. The contract with the ~~PRO~~ QIO -

(1) Meets the requirements of §434.6(a);

(2) Includes a monitoring and evaluation plan to ensure satisfactory performance;

(3) Identifies the services and providers subject to ~~PRO~~ QIO review;

(4) Ensures that ~~PRO~~ QIO review activities are not inconsistent with the ~~PRO~~ QIO review of Medicare services; and

(5) Includes a description of the extent to which ~~PRO~~ QIO determinations are considered conclusive for payment purposes.

___ Quality review requirements described in ~~section 1902(a)(30)(C) of~~ the Act relating to services furnished by HMOs under contract are undertaken through contract with the ~~PRO~~ QIO designated under 42 CFR Part 475.

~~1902(a)(30)(C)~~
1932(c)(2) of the
Act, P.L. ~~99-509~~
105-33 (Section ~~9431~~
4705(a))

___ By undertaking quality review of services furnished under each contract with a HMO through a private accreditation body.

X An entity that meets the requirements of the Act, as determined by the Secretary.

State: MINNESOTA

Citation
42 CFR 456.2
50 FR 15312

4.14 (b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

☐ Utilization and medical review are performed by a Utilization and Quality Control Quality Improvement ~~Peer Review~~ Organization designated under 42 CFR Part 475 that has a contract with the agency to perform those reviews.

☐ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

☐ all hospitals (other than mental hospitals).

☐ those specified in the waiver.

☒ No waivers have been granted.

Revision: HCFA-PM-85-3 (BERC)
July 1985

OMB No. 0938-0193

State: MINNESOTA

Citation
42 CFR 456.2
50 FR 15312

4.14 (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

☐ Utilization and medical review are performed by a Utilization and Quality Control ~~Peer Review~~ Quality Improvement Organization designated under 42 CFR Part 475 that has a contract with the agency to perform those reviews.

☐ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

☐ all mental hospitals.

☐ those specified in the waiver.

☒ No waivers have been granted.

Revision: HCFA-PM-85-3 (BERC)
July 1985

State/Territory: MINNESOTA

Citation

~~42 CFR 456.2~~
~~50 FR 15312~~

4.14(d) ~~The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.~~

___ ~~Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.~~

___ ~~Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:~~

___ ~~All skilled nursing facilities.~~

___ ~~Those specified in the waiver.~~

_X_ ~~No waivers have been granted.~~

Revision: HCFA-PM-85-3 (BERC)
July 1985

State/Territory: MINNESOTA

456

Citation
42 CFR 456.2
50 FR 15312

4.14(e) The Medicaid agency meets the requirements of 42 CFR Part ~~-546-~~, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

X Facility-based review.

___ Direct review by personnel of the medical assistance unit of the State agency.

___ Personnel under contract to the medical assistance unit of the State agency.

___ Utilization and Quality Control ~~Peer Review~~ Quality Improvement Organizations.

___ Another method as described in ATTACHMENT 4.14-A.

___ Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

___ Not applicable. Intermediate care facility services are not provided under this plan.

Revision: HCFA-PM-91-10 (MB)
December 1991

State/Territory: MINNESOTA

Citation

4.14 Utilization/Quality Control (continued)

~~1902(a)(30)~~ 1932(c)(2) and 1902(d) of of the Act, ~~P.L. 99-509 (Section 9431)~~, P.L. 99-203 (Section 4113) P.L. 105-33 (Section 4705(a)

(f) The Medicaid agency meets the requirements of section ~~1902(a)(30)~~ 1932(c) of the Act for control of the assurance of quality furnished by each health maintenance organization under contract with the Medicaid agency. Independent, external quality reviews are performed annually by:

___ A Utilization and Quality Control ~~Peer Review Organization~~ Quality Improvement Organization designated under 42 CFR Part 475 that has a contract with the agency to perform those reviews.

___ A private accreditation body.

_x_ An entity that meets the requirements of the Act, as determined by the Secretary.

The Medicaid agency certifies that the entity in the preceding subcategory under 4.14(f) is not an agency of the State.

(42 CFR §483, Subpart E)

Revision: HCFA-PM-92-2 (HSQB)
MARCH 1992

State/Territory: MINNESOTA

Citation	4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals
42 CFR Part 456 Subpart I, and 1902(a)(31) and 1903(g) of the Act	_X_ The State has contracted with a Peer Review organization (PRO) to perform inspection of care for: _X_ ICFs/MR; _X_ Inpatient psychiatric facilities for recipients under age 21; and ___ Mental Hospitals.
42 CFR Part 456 Subpart A and 1902(a)(30) of the Act	_X_ All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services. ___ Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan. ___ Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan. ___ Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State MINNESOTA

Citation
42 CFR 431.615(c)
AT-78-90

4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Minnesota

4.17 Liens and Adjustments or Recoveries

Citation
42 CFR 433.36(c)
1902(a)(18)
1917(a) & (b)
of the Act

(a) Liens

____ The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFR 433.36(c)– (g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

__X__ The State imposes liens on real property on account of benefits incorrectly paid.

__X__ The State imposes TEFRA liens under §1917(a)(1)(B) on real property an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs, except on property interests disregarded under the long-term care insurance partnership.

__X__ The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (Note: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures and due process requirements.)

__X__ The State imposes liens on both real and personal property of an individual after the individual's death except as provided in (b)(4).

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Minnesota

(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.366(h) – (i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

X Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

(2) The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917(a)(1)(B) (even if it does not impose those liens).

(3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community based services and related hospital and prescription drug services, except as specified in (b)(4).

~~X~~ In addition to adjustment or recovery of payments for services listed above payments are adjusted or recovered for other services under the State plan as listed below:

~~All medical assistance (MA) services except as specified in (b)(4).~~

The revision to paragraph (b)(3) above is effective July 1, 2016 for estate claims pending on or after July 1, 2016 and estates for people who die on or after July 1, 2016.

(4) Limitation on Estate Recovery – Medicare Cost Sharing
(i) Medical assistance for Medicare cost sharing is protected from estate recovery for individuals qualified for a Medicare Savings Program group under 1902(a)(10)(E). This protection extends to the Medicare cost sharing benefits for each group under 1902(a)(10)(E) with dates of service on or after January 1, 2010: for QMB, Part A and B premiums, deductibles and coinsurance; for SLMB and QI, Part B premiums; and for QDWI, Part A premiums. The date of service for Medicare deductibles and coinsurance for QMB individuals is the date the request for payment is received by the State Medicaid agency. The date of service for Medicare Part A or B premiums is the date the State Medicaid Agency pays the premium. Individuals qualified for a Medicare Savings Program group under 1902(a)(10)(E) as QMB and SLMB individuals who also qualify for full Medicaid benefits under another eligibility group, receive the same estate recovery protection as stated above for QMB and SLMB individuals.
(ii) The exemption applies to a qualified individual under 1902(a)(10)(E) who is age 55 or older.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Minnesota

(b) Adjustments or Recoveries cont.

1917(b)(1)(C)

(4) X The State does not seek adjustment or recovery on account of medical assistance paid under (b)(1) through (b)(3) from assets or resources disregarded for an individual covered ~~after benefits are exhausted~~ under a qualified State long-term care insurance partnership policy. The State adjusts or recovers only to the extent assets or resources in the estate exceed assets or resources protected by the partnership program. For a deceased recipient who qualifies for partnership participation, the estate subject to recovery is described in Attachment 4.17-A.

_____ The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy and the requirements in Attachment 2.6-A, Supplement 8b.

_____ The State adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long term care insurance policy-based asset or resource disregard must select this entry. These five States may either check this entry or one of the following entries.)

_____ The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.

_____ The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Minnesota

(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917 (b)(2) of the Act and regulations at 42 CFR §433.36 (h)-(i).

(1) Adjustment ~~of~~ or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.

(2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:

(a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or

(b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.

(3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

(4) Because the State has resolved its claims in connection with In re Factor VIII or IX Concentrate Blood Products Litigation, MDL-986m Bi, 93-C7452 (N.D. Ill)(consolidated under Case No. 96-C5024), the State will not seek adjustment or recovery of medical assistance benefits correctly paid on behalf of a member of the settlement class in such case from the settlement payment made to a member of the settlement class or to his or her estate.

P.L. 105-369

(5) A payment under the Ricky Ray Hemophilia Relief Fund Act of 1998 is not subject to adjustment or recovery for medical assistance benefits correctly paid.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: MINNESOTA

(d) ATTACHMENT 4.17-A

(1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).

(2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).

(3) Defines the following terms:

- estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),
- individual's home,
- equity interest in the home,
- residing in the home for at least 1 or 2 years,
- on a continuous basis,
- discharge from the medical institution and return home, and
- lawfully residing.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: MINNESOTA

(4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.

(5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.

(6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

State: Minnesota

Reserved

~~Citation 4.18 Recipient Cost Sharing and Similar Charges~~

~~42 CFR 447.51 through 447.58~~ ~~(a) Unless a waiver under 42 CFR 431.57 applies, deductibles coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.~~

~~1916(a) and (b) of the Act~~ ~~(b) Except as specified in items 4.18(b)(4), (5), (6) and (7) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan;~~

~~(1) No enrollment fee, premium, or similar charge is imposed under the plan.~~

~~(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:~~

~~(i) Services to individuals under age 18, or under~~

~~___ Age 19~~
~~___ Age 20~~
~~_X_ Age 21~~

~~Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.~~

(ii) ~~Services to pregnant women related to the pregnancy or any other medical conditions that may complicate the pregnancy.~~

State/Territory: MINNESOTA

Reserved

~~Citation 4.18(b) (Continued)~~

~~42 CFR 447.51 through 447.58~~	~~(iii) All services furnished to pregnant women.~~ ~~☐ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.~~
	~~(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his or her income required for personal needs.~~
	~~(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).~~
	~~(vi) Family planning services and supplies furnished to individuals of childbearing age.~~
~~1916 of the Act, P.L. 99-272 (Section 9505)~~	~~(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.~~
~~1916 of the Act, P.L. 111-5 (Section 5006)~~	~~(viii) Items or services furnished to an American Indian directly by the Indian Health Services, an Indian Tribe or Tribal Organization, or an Urban Indian Organization or through referral under contract health services for which payment may be made under Title XIX of the Social Security Act.~~

Revision: HCFA-PM-91- August 1991 (BPD) OMB No.: 0938-

State/Territory: MINNESOTA

Reserved

~~Citation 4.18(b) (Continued)~~

~~42 CFR 447.51~~

~~(3) Unless a waiver under 42 CFR 431.57 applies, *nominal* deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.~~

~~☐ Not applicable. No such charges are imposed.~~

~~(i) For any service, no more than one type of charge is imposed.~~

~~(ii) Charges apply to services furnished to the following age groups:~~
~~☐ 18 or older~~
~~☐ 19 or older~~
~~☐ 20 or older~~
~~X 21 or older~~

~~Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.~~

Revision: HCFA-PM-91- August 1991 (BPD) OMB No.: 0938-

State/Territory: MINNESOTA

Reserved

~~Citation~~ ~~4.18(b)(3) (Continued)~~

~~42 CFR 447.51 through 447.58~~

~~(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:~~

~~(A) Service(s) for which a charge(s) is applied;~~

~~(B) Nature of the charge imposed on each service;~~

~~(C) Amount(s) of and basis for determining the charge(s);~~

~~(D) Method used to collect the charge(s);~~

~~(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;~~

~~(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and~~

~~(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.~~

~~☐ Not applicable. There is no maximum.~~

Revision: HCFA-PM-91 (BPD)
August 1991

OMB No.: 0938

State: Minnesota

Citation		
1916(c)	4.18(b)(4)	____ A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. Attachment 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.
1902(a)(52) and 1925(b) of the Act	4.18(b)(5)	_____ For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.
1916(d) of the Act	4.18(b)(6)	_____ A monthly premium, set on a sliding scale, imposed on Qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent_ of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. A TTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.
1916(g) of the Act	4.18(b)(7)	__X_ Premiums are imposed on individuals under section 1902(a)(10)(A)(ii), subclause XIII, subclause (XV) or subclause (XVI) as described in Attachment 2.6-A.
1916(j) of the Act	4.18(b)(8)	No premium, enrollment fee or similar charge is imposed against an American Indian who is eligible for or has been furnished services directly by the Indian Health Services, an Indian Tribe or Tribal Organization, or an Urban Indian Organization or through referral under contract health services for which payment may be made under Title XIX of the Social Security Act.

Revision: HCFA-PM-91- August 1991 (BPD) OMB No.: 0938-

State/Territory: MINNESOTA

Citation

4.18(c) X Individuals are covered as medically needy under the plan.

42 CFR 447.51 through 447.58

(1) ☐ An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-C specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

~~447.51 through 447.58~~

~~(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:~~

~~(i) Services to individuals under age 18, or under--~~

~~Age 19~~
~~Age 20~~
~~X Age 21~~

~~Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:~~

State/Territory: MINNESOTA

Reserved

~~Citation~~ ~~4.18(c)(2) (Continued)~~

~~42 CFR 447.51 through 447.58~~

~~(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.~~

~~(iii) All services furnished to pregnant women.~~

~~☐ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.~~

~~(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.~~

~~(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).~~

~~(vi) Family planning services and supplies furnished to individuals of childbearing age.~~

~~1916 of the Act, P.L. 99-272 (Section 9505)~~

~~(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.~~

~~1916 of the Act, P.L. 111-5 (Section 5006)~~

~~(viii) Items or services furnished to an American Indian directly by the Indian Health Services, an Indian Tribe or Tribal Organization, or an Urban Indian Organization or through referral under contract health services for which payment may be made under Title XIX of the Social Security Act.~~

Revision: HCFA-PM-91- (BPD) August 1991 OMB No.: 0938-

State/Territory: MINNESOTA

Reserved

~~Citation~~

~~447.51 through 447.58~~

~~4.18(c)(3) Unless a waiver under 42 CFR 431.57 applies, *nominal* deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.~~

~~☐ Not applicable. No such charges are imposed.~~

~~(i) For any service, no more than one type of charge is imposed.~~

~~(ii) Charges apply to services furnished to the following age group:~~

~~18 or older~~
~~19 or older~~
~~20 or older~~
~~X 21 or older~~

~~Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.~~

~~(iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:~~

~~(A) Service(s) for which charge(s) is applied;~~

~~(B) Nature of the charge imposed on each service;~~

~~(C) Amount(s) of and basis for determining the charge(s);~~

~~(D) Method used to collect the charge(s);~~

~~(E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;~~

Revision: HCFA-PM-91- August 1991 (BPD) OMB No.: 0938-

State/Territory: MINNESOTA

Reserved

~~Citation~~ ~~4.18(c)(3) Continued~~

~~447.51 through 447.58~~

~~(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and~~

~~(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.~~

~~☐ Not applicable. There is no maximum.~~

Revision: HCFA-PM-93-5 (MB)
MAY 1993

State/Territory: MINNESOTA

Citation	4.19 Payment for Services
42 CFR 447.252 1902(a)(13), 1902(e)(7), and 1923	(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13), 1902(e)(7), and 1923 of the Act with respect to payment for inpatient hospital services. ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services. x Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act. ___ Inappropriate level of care days are not covered.

Revision: HCFA-PM-93-6 (MB) OMB No.: 0938-
August 1993

State/Territory: MINNESOTA

Citation	4.19(b)
42 CFR 447.201 42 CFR 447.302 52 CFR 28648 1902(a)(15), 1902(aa), 1903(a)(1) and 1920 of the Act, Sec. 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (incorporated by reference in P.L. 106-554)	In addition to the services specified in paragraphs 4.19(a), (d), (k), ~~(l), and (m),~~ the Medicaid agency meets the following requirements: (1) Section ~~1902(a)(13)(E)~~ 1902(aa) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. ~~The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services.~~ ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys). (2) ~~Sections 1902(a)(13)(B) and 1926~~ Section 1902(aa) of the Act~~,~~ and 42 CFR Part 447.371 ~~, Subpart D,~~ with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan. ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.
1902(a)(10) and 1902(a)(30) of the Act	SUPPLEMENT 1 TO ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

Citation
42 CFR 447.40
AT-78-90

4.19(c) Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

☒ Yes. The State's policy is described in ATTACHMENT 4.19-C.

☐ No.

Revision: HCFA-PM-87-9 (BERC) OMB No.: 0938-0193
August 1987

State/Territory: MINNESOTA

Citation 4.19(d)

42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141

☒ (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for ~~skilled~~ nursing facility and intermediate care facility services.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for ~~skilled~~ nursing facility and intermediate care facility services.

(2) The Medicaid agency provides payment for routine ~~skilled~~ nursing facility services furnished by a swing-bed hospital. Swing-bed hospitals are also subject to State statute limitations:

☒ At the average rate per patient day paid to ~~SNFs~~ nursing facilities for routine services furnished during the previous calendar year.

☐ At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

☐ Not applicable. The agency does not provide payment for ~~SNF~~ nursing facility services to a swing-bed hospital.

(3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

☐ At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

☐ At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

☒ Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

☐ (4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

Citation		
42 CFR 447.45(c) AT-79-50	4.19(e)	The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims. ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

TN # 79-26
Supersedes
TN # _____

Approval Date 2-6-80 Effective Date 10-1-79

State/Territory: MINNESOTA

Citation	4.19 Payment for Services
Section 1903(i)(17) of the Act	No Medical Assistance payment will be made with respect to any amount expended for items or services not covered under Minnesota's State plan.

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Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
March 1987

State/Territory: MINNESOTA

Citation		
42 CFR 447.15 AT-78-90 AT-80-34 48 FR 5730	4.19(f)	The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447. 15. No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR ~~431.55(g) and~~ 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing charge.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

Citation		
42 CFR 447.201 42 CFR 447.202 AT-78-90	4.19(g)	The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

Revision: HCFA-AT-80-60 (BPP)
August 12, 1980

State MINNESOTA

Citation		
42 CFR 447.201 42 CFR 447.203 AT-78-90	4.19(h)	The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

TN # 80-25
Supersedes
TN # 75-4

Approval Date 12-16-80
3.18.75

Effective Date 10-1-80
1-1-75

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

Citation	4.19(i)
1902 (a) (30) (A) 42 CFR 447.201 42 CFR 447.204 At – 78 - 90	

The Medicaid agency provides methods and procedures relating to the utilization of, and the payment for, care and services available under the State plan as may be necessary to safeguard against unnecessary utilization of such care and services. The Medicaid agency's payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population in the geographic area.

The rate methodologies are the same for both governmental and private providers, except as otherwise noted in the plan.

The base rates for payments that are fixed across all providers are available on the agency's website http://www.dhs.state.mn.us in the Minnesota Health Care Program fee schedules. Methodologies for determining any adjustments to the base rates are ~~found through the Minnesota Health Care Program Provider Manual~~ available through the agency's website or through the Provider Help Desk at 1-800-366-5411 or 651-431-2700.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State: MINNESOTA

Citation

42 CFR 447.201 and 447.205	4.19(j)	The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.
1903(v) of the Act	(k)	The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: MINNESOTA

Citation

1903(i)(14) of the Act	4.19(1)	The Medicaid agency meets the requirements of section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physician to a child or a pregnant women is made only to physicians who meet one of the requirements listed under this section of the Act.

Revision: **HCFA-PM-94-8 (MB)**
OCTOBER 1994

State/Territory: Minnesota

Citation

4.19(m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928(c)(2)(C)(ii) of the Act (i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.

(ii) The State:

~~X~~ sets a payment rate at the level of the regional maximum established by the DHHS Secretary.

is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

X sets a payment rate below the level of the regional maximum established by the DHHS Secretary.

is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The State pays the following rate for the administration of a vaccine: payment for administration of the vaccine is described in item 5.a., of Attachment 4.19-B.

1926 of the Act (iii) Medicaid beneficiary access to immunizations is assured through the following methodology:

- The State will perform outreach to encourage a variety of providers to participate in the program and to administer vaccines in multiple settings (e.g., private health care providers, providers that receive funds under Title V of the Indian Health

Care Improvement Act, health programs or facilities operated by Indian tribes), and maintain a list of program-registered providers.

- With respect to any population of vaccine-eligible children, a substantial portion of whose parents have limited ability to speak the English language, the State will identify program registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.

- The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.

- Except as authorized under section 1915(b) of the Social Security Act, or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated in the state plan, in order for a provider to qualify as a program registered provider.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

Citation
42 CFR 447.25(b)
AT-78-90

4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

☐ Yes, for ☐ physicians' services

☐ dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

☒ Not applicable. No direct payments are made to recipients.

Revision: HCFA-AT-81-34 (BPP) 10-81

State MINNESOTA

Citation	4.21 Prohibition Against Reassignment of Provider Claims
42 CFR 447.10(c) AT-78-90 46 FR 42699	Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.

TN # 81-31
Supersedes
TN # 78-16

Approval Date 12/22/81
7/21/78

Effective Date 10/1/81
4/1/78

State: Minnesota

Citation

4.22 Third Party Liability

42 CFR 433.137

(a) The Medicaid agency meets all the requirements of:

(1) 42 CFR 322.138 and 433.139
(2) 42 CFR 433.145 through 433.148
(3) 42 CFR 433.151 through 433.154
(4) Sections 1902(a)(25)(G) and (H) of the Act.

42 CFR 433.138

(b) **Attachment 4.22-A -**

(1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;

(2) Describes the methods the agency uses for meeting the follow up requirements contained in §433.138(g)(1)(i) and (g)(2)(i);

(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation in to the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow up that identifies legally liable third party resources; and

(4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collection and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow up that identifies legally liable third party resources.

Revision: HCFA-PM-94-1 (MB)
February 1994

State: Minnesota

4.22 (continued)

Citation		
42 CFR 433.139(b)(3)(ii)(A)	_X_	(c) Providers are required to bill liable third parties when services under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.
		(d) Attachment 4.22-B specifies the following:
42 CFR 433.139(b)(3)(ii)(C)		(1) The methods used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C).
42 CFR 433.139(f)(2)		(2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.
42 CFR 433.139(f)(3)		(3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
42 CFR 447.20		(e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restriction specified in 42 CFR 447.20.
1902(a)(25(I)(f)		The Medicaid agency ensures that laws are in effect that bar liable third-party payers from refusing payment for an item or service solely on the basis that such item or service did not receive prior authorization under the third-party payer's rules. These laws comply with the provisions of section 202 of the Consolidated Appropriations Act, 2022.
42 CFR 433.151(a)		(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party

benefits assigned to the State as a condition of eligibility for medical assistance with the following:

_X_ State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

___ Other appropriate State agency(s)

___ Courts and law enforcement officials.

1902(a)(60) of the Act

(g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

___ The Secretary's method as provided in the State Medicaid Manual, section 3910.

_X_ The State provides methods for determining cost effectiveness on Attachment 4.22-C.

(i) Third Party Limitations

- Because the State has resolved its claims in connection with In re Factor VIII or IX Concentrate Blood Products Litigation, MDL-986M Bi, 93-C7452 (N.D. ILL) (consolidated under Case No. 96-C5024), the State will not subject a settlement payment under this case to (by subrogation or otherwise) third party liability for medical assistance benefits correctly paid on behalf of a member of the settlement class.

P.L. 105-369

- A payment under the Ricky Ray Hemophilia Relief Fund Act of 1998 is not (by subrogation or otherwise) treated as a third party payment nor is such payment subject to recovery, recoupment, reimbursement, or collection with respect to medical assistance benefits correctly received.

P.L. 109-171

(j) The state has enacted laws to comply with the provisions of section 6035 of the Deficit Reduction Act of 2005 amending §1902(a)(25)(I)of the Act.

Revision: HCFA-AT-84-2(BERC) 01-84 OMB No. 0938-0193

State: MINNESOTA

Citation

4.23 Use of Contracts

42 CFR Part 434.4
48 FR 54013

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

___ Not applicable. The State has no such contracts.

42 CFR Part 438

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 438. All contracts meet the requirements of 42 CFR Part 438. Risk contracts are procured through ~~an~~ a statewide competitive ~~open~~ procurement process that is consistent with 2 CFR Part 200, ~~45 CFR Part 92. The state does not use a competitive bid process but contracts with any willing and qualified provider that meets the State's contract standards for managed care organizations, with the following exception. The state uses a competitive bid process for twenty seven counties in northern, central, and southeastern Minnesota and the seven county Twin Cities' metropolitan area~~ for contracts affecting families and children and recipients described in Attachment 3.1-F, at D.1. The risk contract is with:

x a managed care organization that meets the definition of §1903(m) of the Act and 42 CFR §438.2

___ a prepaid inpatient health plan that meets the definition of 42 CFR §438.2

___ a prepaid ambulatory health plan that meets the definition of 42 CFR §438.2

___ not applicable.

Revision: HCFA-PM-94-2 (BPD)
APRIL 1994

State: MINNESOTA

Citation	4.24	Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services
42 CFR 442.10 and 442.100 AT-78-90 AT-79-18 AT-80-25 AT-80-34 52 FR 32544 P.L. 100-203 (Sec. 4211) 54 FR 5316 56 FR 48826		With respect to nursing facilities and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met. ___ Not applicable to intermediate care facilities for the mentally retarded; such services are not provided under this plan.

Revision: July 1, 1989

State: MINNESOTA

Citation		
42 CFR 431.702 AT-78-90 1919(d)(1)(C) 1919(e)(4) 1919(f)(4)	4.25	Nursing Facility Administrator Standards The State has a program that, except with respect to ~~Christian Science sanitoria~~ religious nonmedical health care institutions, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

Revision: HCFA-PM- (MB)

State: MINNESOTA

Citation	4.26 Drug Utilization Review Program
1927(g) 42 CFR 456.700	A.1. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.
1927(g)(1)(A)	2. The DUR program assures that prescriptions for outpatient drugs are: - Appropriate - Medically necessary - Are not likely to result in adverse medical results
1927(g)(1)(A) 42 CFR 456.705(b) and 456.709(b)	B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as: - Potential and actual adverse drug reactions - Therapeutic appropriateness - Overutilization and underutilization - Appropriate use of generic products - Therapeutic duplication - Drug disease contraindications - Drug-drug interactions - Incorrect drug dosage or duration of drug treatment - Drug-allergy interactions - Clinical abuse/misuse
1927(g)(1)(B) 42 CFR 456.703(d) and (f)	C. The DUR program shall assess data on drug use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia: - American Hospital Formulary Service Drug Information - United States Pharmacopeia-Drug Information - American Medical Association Drug Evaluations - DRUGDEX Information System

Revision: HCFA-PM- (MB)

State: MINNESOTA

Citation

1927(g)(1)(D) D. DUR is not required for drugs dispensed to 42 CFR 456.703(b) residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs in:

X Prospective DUR
X Retrospective DUR

1927(g)(2)(A)
42 CFR 456.705(b) E.1. The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.

1927(g)(2)(A)(i)
42 CFR 456.705(b), (1)-(7) 2. Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to:

- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Drug-interactions with non-prescription or over-the-counter drugs
- Incorrect drug dosage or duration of drug treatment
- Drug allergy interactions
- Clinical abuse/misuse

1927(g)(2)(A)(ii)
42 CFR 456.705(c) and (d) 3. Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.

1927(g)(2)(B)
42 CFR 456.709(a) F.1. The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:

- Patterns of fraud and abuse
- Gross overuse
- Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs

Revision: HCFA-PM- (MB)

State: MINNESOTA

Citation		
1927(g)(2)(C) 42 CFR 456.709(b)	F.2.	The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for: - Therapeutic appropriateness - Overutilization and underutilization - Appropriate use of generic products - Therapeutic duplication - Drug-disease contraindications - Drug-drug interactions - Incorrect drug dosage/duration of drug treatment - Clinical abuse/misuse
1927(g)(2)(D) 42 CFR 456.711	3.	The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.
1927(g)(3)(A) 42 CFR 456.716(a)	G.1.	The DUR program has established a State DUR Board either: X Directly, or ___ Under contract with a private organization
1927(g)(3)(B) 42 CFR 456.716 (a) and (b)	2.	The DUR Board membership includes health professionals (at least one-third licensed actively practicing pharmacists and at least one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following: - Clinically appropriate prescribing of covered outpatient drugs - Clinically appropriate dispensing and monitoring of covered outpatient drugs - Drug use review, evaluation and intervention - Medical quality assurance
1927(g)(3)(C) 42 CFR 456.716(d)	3.	The activities of the DUR Board include: - Retrospective DUR - Application of Standards as defined in section 1927(g)(2)(C), and - Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR

Revision: HCFA-PM- (MB) OMB No.

State: MINNESOTA

Citation			
1927(g)(3)(C) 42 CFR 456.711 (a)-(d)		G.4.	The interventions include in appropriate instances: - Information dissemination - Written, oral, and electronic reminders - Face-to-face discussions - Intensified monitoring/review of prescribers/dispensers
1927(g)(3)(D) 42 CFR 456.712 (a) and (b)		H.	The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.
1927(h)(1) 42 CFR 456.722	x	I.1.	The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line: - real time eligibility verification - claims data capture - adjudication of claims - assistance to pharmacists, etc. applying for and receiving payment
1927(g)(2)(A)(i) 42 CFR 456.705(b)	x	2.	Prospective DUR is performed using an electronic point-of-sale drug claims processing system.
1927(j)(2) 42 CFR 456.703(c)		J.	Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.

*U.S. G.P.O.:1993-342-139:80043

Citation	
1902(a)(85) and Section 1004 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)	K. Review and Limitations for Opioid Claims. The state will perform the following reviews and actions for claims related to opioids: 1. Prospective safety edits on opioid prescriptions for early duplicate, early refills, and fills in excess of clinically appropriate standards. 2. Prospective safety edits to limit maximum daily morphine milligram equivalents (MME) as recommended by clinical guidelines. 3. Ongoing, retrospective reviews on opioid prescriptions in excess of limits. 4. Ongoing, retrospective reviews for concurrent utilization of opioids and benzodiazepines, and concurrent utilization of opioids and antipsychotics. L. Programs to Monitor Antipsychotic Medications to Children. The state will review prescriptions for antipsychotic agents for appropriateness for all children, including children in foster care, for clinic appropriateness. M. Fraud and Abuse Identification. The DUR program includes a process that identifies potential fraud or abuse of controlled substances by enrollees and/or health care providers.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

Citation		
42 CFR 431.115(c) AT-78-90 AT-79-74	4.27	Disclosure of Survey Information and Provider or Contractor Evaluation The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

Revision: HCFA-PM-93-1 (BPD)
January 1993

State: MINNESOTA

Citation	4.28	Appeals Process
42 CFR 431.152; AT-79-18 52 FR 22444; Secs. 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)) P.L. 104-315 (Secs. 1(a)(1)) & (2))	(a)	The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154.
	(b)	The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and ~~annual~~ resident review requirements of 42 CFR 483 Subpart C.

Revision: HCFA-PM-99-3 (CMSO)
June 1999

State/Territory: MINNESOTA

Citation	4.29 Conflict of Interest Provisions
§1902(a)(4)(C) of the Act; P.L. 95-559, §14; P.L. 105-33, §4724(c)	The Medicaid agency meets the requirements of §1902(a)(4)(C) of the Act concerning the prohibition against acts, with respect to any activity under the plan, that are prohibited by §207 or §208 of Title 18, United States Code.
§1902(a)(4)(D) of the Act; P.L. 105-33; §4724(c); §1932(d)(3) 42 CFR §438.58	The Medicaid agency meets the requirements of §1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under §27 of the Office of Federal Procurement Policy Act (41 U.S.C. §423).

Revision: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: MINNESOTA

Citation
42 CFR 1002.203
AT-79-54
48 FR 3742
51 FR 34772

4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals

(a) All requirements of 42 CFR Part 1002, Subpart B are met.

/X/ The agency, under the authority of State law, imposes broader sanctions.

Revision: HCFA-AT-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: MINNESOTA

Citation	
	(b) The Medicaid agency meets the requirements of--
§1902(p)(1) of the Act; P.L. 100-93 (sec.7)	(1) Section 1902(p) of the Act by excluding from participation--
	(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under Title XVIII in accordance with §§1128, 1128A, or 1866(b)(2).
§1902(p)(2) of the Act; P.L. 101-239; P.L. 105-33 42 CFR 438.808	(B) Any Medicaid managed care organization (as defined in §1903(m) of the Act) or an entity furnishing services under a waiver approved under §1915(b)(1) of the Act, that--
	(i) Could be excluded under §1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions,
	(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in §1128(b)(8)(B) of the Act, or
	(iii) Employs or contracts with any individual or entity that is excluded from participation under §1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for providing (directly or indirectly) through such an excluded individual or entity of such services.
§1932(d)(1) 42 CFR 438.610	(2) Section 1932(d)(1) of the Act by prohibiting MCO affiliations with individuals debarred by federal agencies. A MCO may not knowingly have affiliations with individuals (as defined in 42 CFR §438.610(b)) who are suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from

Citation		
		participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing such order, including an affiliate of such individuals. If the State finds that a MCO is not in compliance, the State takes the actions in 42 CFR §438.610(c).
§1902(a)(23) of the Act	(3)	Section 1902(a)(23) of the Act by barring or suspending from participation a Medicaid provider convicted of a felony under state or federal law when the State determines that the felony is inconsistent with the best interests of the recipients under the State plan.
§1902(a)(39) of the Act; P.L. 100-03 (sec. 8(f))	(4)	Section 1902(a)(39) of the Act by -- (A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with §§1128 or 1128A of the Act; and (B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.
	(c)	The Medicaid agency meets the requirements of--
§1902(a)(41) of the Act; P.L. 96-272 (sec.308(c)(3)) and P.L.101-508	(1)	§1902(a)(41) of the Act with respect to prompt notification to CMS whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan (and in the case of a physician, notification to the State medical licensing board); and
§1902(a)(49) of the Act; P.L. 100-93 (sec. 5(a)(4))	(2)	§1902(a)(49) of the Act with respect to providing information and access to information respecting sanctions taken against health care practitioners and providers by State licensing authorities in accordance with §1921 of the Act.

Revision: HCFA-PM-87-14 (MB)
October 1987

OMB No: 0938-0193

State: Minnesota

Citation		
455.103 44 FR 41644 1902(a)(38) 100-93, sec. 8(f)	4.31	Disclosure of Information by Providers and Fiscal Agents The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR P.L. 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.
435.940 - 435.960 52 FR 5967	4.32	Income and Eligibility Verification System (a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960. (b) Attachment 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested. (c) The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: MINNESOTA

Citation
1902(a)(48) of the Act, P.L. 99-570 (Section 11005) P.L 100-93 (sec. 5(a)(3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1987— 201-818/60437

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

Citation 4.34 Systematic Alien Verification for Entitlements

1137 of the Act

The State Medicaid agency has established procedures for the verification of alien status through the Immigration and Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1998.

[ ] The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

[ ] The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

[ ] Total Waiver

[ ] Alternative system

[ ] Partial implementation

P.L. 104-193
P.L. 104-208 and 105-33

[X] The State Medicaid agency has established procedures for the verification of alien status through the SAVE system designated by the INS.

Revision: HCFA-PM-985-4 HSQB)
June 1995

State: MINNESOTA

Citation 4.35 Enforcement of Compliance for Nursing Facilities

42 CFR §488.402(f) (a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR §488.402(f)(2).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

(1) nature of noncompliance,
(2) which remedy is imposed,
(3) effective date of the remedy, and
(4) right to appeal the determination leading to the remedy.

42 CFR §488.434 (ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR §488.434.

42 CFR §488.402(f) ~~(2)~~ (3), (4) (iii) Except for civil money penalties and State monitoring, notice is given at least two calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

42 CFR §488.456(c), (d) (iv) Notification of termination is given to the facility and to the public at least two calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Facilities

42 CFR §488.404(b)(1) (i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR §488.404(b)(1) & (2).

___ The State considers additional factors. Attachment 4.35-A describes the State's other factors.

Revision: HCFA-PM-95-4 (HSQB)
June 1995

State: MINNESOTA

Citation		
	(c)	Application of Remedies
42 CFR §488.410	(i)	If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.
42 CFR §488.417(b) §1919(h)(2)(C) of the Act	(ii)	The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within three months after the last day of the survey.
42 CFR §488.414 §1919(h)(2)(D) of the Act	(iii)	The State imposes the denial of payment for new admissions remedy as specified in 42 CFR §488.417 (or its approved alternative) and a State monitor as specified at 42 CFR §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.
42 CFR §488.408 §1919(h)(2)(A) of the Act	(iv)	The State follows the criteria specified at 42 CFR §§488.408(c)(2), 488.408(d)(2), and 488.408(e)(2), when it imposes remedies in place of or in addition to termination.
42 CFR §488.412(a)	(v)	When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than six months from the finding of noncompliance, if the conditions of 42 CFR §488.412(a) are not met.
	(d)	Available Remedies
42 CFR §488.406(b) §1919(h)(2)(A) of the Act	(i)	The State has established the remedies defined in 42 CFR §488.406(b).

x (1) Termination
x (2) Temporary Management
x (3) Denial of Payment for New Admissions
x (4) Civil Money Penalties
x (5) Transfer of Residents; Transfer of Residents with Closure of Facility
x (6) State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

State/Territory: _____

Citation

42 CFR
§488.406(b)
§1919(h)(2)(B)(ii)
of the Act.

(ii) ___ The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406(b).

___ (1) Temporary Management
___ (2) Denial of Payment for New Admissions
___ (3) Civil Money Penalties
___ (4) Transfer of Residents; Transfer of Residents with Closure of Facility
___ (5) State Monitoring.

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

42 CFR
§488.303(b)
1910(h)(2)(F)
of the Act.

(e) ___ State Incentive Programs

___ (1) Public Recognition
___ (2) Incentive Payments

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State/Territory: MINNESOTA

Citation	4.36	Required Coordination Between the Medicaid and WIC Programs
1902(a)(11)(C) and 1902(a)(53) of the Act		The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

Revision: HCFA-PM-91-10
DECEMBER 1991

State/Territory: MINNESOTA

Citation			4.38 Nurse Aide Training and Competency Evaluation for Nursing Facilities
42 CFR §483.75; 42 CFR §483, Subpart D; §§1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2); P.L. 100-203 (§4211(a)(3)); P.L. 101-239 (§§6901(b)(3) and (4)); P.L. 101-508 (§4801(a)); P.L. 105-15 (§1)	X	(a)	The State assures that the requirements of 42 CFR §483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.
	x	(b)	The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR §483.150(b)(1).
	x	(c)	The State deems individuals who meet the requirements of 42 CFR §483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.
		(d)	The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR §483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR §483.154.
	x	(e)	The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR §483.152.
	x	(f)	The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR §483.154.
		(g)	If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.

Revision: HCFA-PM-91-10 (BPD)
DECEMBER 1991

State/Territory: MINNESOTA

Citation		
42 CFR §483.75; 42 CFR 483, Subpart D; §§1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2); P.L. 100-203 (§4211(a)(3)); P.L. 101-239 (§§6901(b)(3) and (4)); P.L. 101-508 (§4801(a)); P.L. 105-15 (§1).	(h)	The State survey agency determines, during the course of all surveys, whether the requirements of 42 CFR §483.75(e) are met.
	(i)	Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR §483.152 are met.
	(j)	Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR §483.154 are met.
	(k)	For program reviews other than the initial review, the State visits the entity providing the program.
	(l)	Except as noted, the State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR §483.151(b)(2) and (3). This does not apply to a program offered in (but not by) a facility if the State:
		(i) determines that there is not another program offered within a reasonable distance of the facility;
		(ii) assures, through an oversight effort, that an adequate environment exists for operating the program in the facility; and
		(iii) provides notice of such determination and assurances to the State long-term care ombudsman.

Revision: HCFA-PM-91-10 (BPD)
DECEMBER 1991

State/Territory: MINNESOTA

Citation		
42 CFR §483.75; 42 CFR §483, Subpart D; §§1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2); P.L. 100-203 (§4211(a)(3)); P.L. 101-239 (§§6901(b)(3) and (4)); P.L. 101-508 (§4801(a)); P.L. 105-15 (§1)	(m)	The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.
	(n)	The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.
	(o)	The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).
	(p)	Except as noted in item (l), above, the State withdraws approval from nurse aide training and competency evaluation program and competency evaluation programs when the program is described in 42 CFR §483.151(b)(2) or (3).
x	(q)	The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR §483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR §483.154.
	(r)	The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.
	(s)	When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.

Revision: HCFA-PM-91-10 (BPD)
DECEMBER 1991

State/Territory: MINNESOTA

Citation		
42 CFR §483.75; 42 CFR §483, Subpart D; §§1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2); P.L. 100-203 (§4211(a)(3)); P.L. 101-239 (§§6901(b)(3) and (4)); P.L. 101-508 (§4801(a)); P.L. 105-15 (§1)	(t)	The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.
	(u)	The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.
	(v)	The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.
	(w)	Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.
x	(x)	The State permits proctoring of the competency evaluation in accordance with 42 CFR §483.154(d).
	(y)	The State has a standard for successful completion of competency evaluation programs.
	(z)	The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
x	(aa)	The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).

Revision: HCFA-PM-91-10 (BPD)
DECEMBER 1991

State/Territory: MINNESOTA

Citation		
42 CFR §485.75; 42 CFR §483, Subpart D; §§1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2); (§4211(a)(3)); P.L. 101-239 (§§6901(b)(3) and (4)); P.L. 101-508 (§4801(a)); P.L. 105-15 (§1)		(bb) The State maintains a nurse aide registry that meets the requirements in 42 CFR §483.156.
	x	(cc) The State may include home health aides on the registry.
	___	(dd) The State contracts the operation of the registry to a non State entity.
	x	(ee) ATTACHMENT 4.38 contains the State's description of its nurse aide training and competency evaluation programs, and nurse aide registry.
	x	(ff) ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR §483.156(c).

Revision: HCFA-PM-3-1 (BPD)
January 1993

State: MINNESOTA

Citation		4.39 Preadmission Screening and ~~Annual~~ Resident Review in Nursing Facilities
Sections 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)); P.L. 101-508 (Sec. 4801(b)); P.L. 104-315, (Secs. 1(a)(1) & (2))	(a)	The Medicaid agency is the same agency as the State mental health and mental retardation authority.
	(b)	The ~~State~~ operates a preadmission and ~~annual~~ resident review program that meets the requirements of 42 CFR 483.100-138.
	(c)	The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or ~~annual~~ resident review until such individuals are screened or reviewed.
	(d)	With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as "medical assistance under the State Plan" the cost of NF services to individuals who are found not to require NF services.
x	(e)	ATTACHMENT 4.39 specifies the State's definition of specialized services.

Revision: HCFA-PM-93-1 (BPD)
January 1993

State: MINNESOTA

4.39 (Continued)

___ (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.

(g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.

Revision: HCFA-PM-92-3 (HSQB) OMB No.:
APRIL 1992

State/Territory: MINNESOTA

Citation	4.40 Survey and Certification Process	
§§1919(g)(1), (2), (4) and (5); P.L. 100-203 (§4212 (a)); P.L. 105-33 (§4755(b)).	(a)	The State assures that the requirements of §1919(g)(1) and (2) of the Act which relate to the survey and certification of non-State owned nursing facilities based on the requirements of §1919(b), (c) and (d) of the Act, are met.
§1919(g)(1)(B)	(b)	The State conducts periodic educational programs for staff and residents (and their representatives). ATTACHMENT 4.40-A describes the survey and certification educational program.
§1919(g)(1)(C) and (D); P.L. 105-33 (§4755(b))	(c)	The State provides for a process for the receipt, and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or by another individual providing services to residents. ATTACHMENT 4.40-B describes the State's process and the opportunity, in limited circumstances, for nurse aides to petition for removal of their name from the Nurse Aide Registry if there is a finding of neglect.
§1919(g)(1)(C)	(d)	The State agency responsible for surveys and certification of nursing facilities conducts the process for the receipt, and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property.
§1919(g)(1)(C)	(e)	The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property, is notified of the finding. The name and finding is placed on the nurse aide registry.
§1919(g)(1)(C)	(f)	The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property.

Revision: HCFA-PM-92-3 (HSQB)
APRIL 1992

OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: MINNESOTA

1919(g)(2)(A)(i) of the Act	(g)	The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. Attachment 4.40-C describes the State's procedures.
1919(g)(2)(A)(ii) of the Act	(h)	The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.
1919(g)(2)(A)(iii)(I) of the Act	(i)	The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.
1919(g)(2)(A)(iii)(II) of the Act	(j)	The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.
1919(g)(2)(B) of the Act	(k)	The State conducts extended surveys immediately or, if not practicable, not later than 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.
1919(g)(2)(C) of the Act	(l)	The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

Revision: HCFA-PM-92-3 (HSQB)
APRIL 1992 OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: MINNESOTA

1919(g)(2)(D) of the Act	(m)	The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. Attachment 4.40-D describes the State's programs.
1919(g)(2)(e)(i) of the Act	(n)	The State uses a multidisciplinary team of professionals including a registered professional nurse.
1919(g)(2)(E)(ii) of the Act	(o)	The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.
1919(g)(2)(E)(iii) of the Act	(p)	The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.
1919(g)(4) of the Act	(q)	The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and on site monitoring. Attachment 4.40-E describes the State's complaint procedures.
1919(g)(5)(A) of the Act	(r)	The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.
1919(g)(5)(B) of the Act	(s)	The State notifies the State long-term care ombudsman of the State's finding of noncompliance with any of the requirements of subsection (b), (c), and (d), or of any adverse actions taken against a nursing facility.
1919(g)(5)(C) of the Act	(t)	If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.
1919(g)(5)(D) of the Act	(u)	The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

Revision: HCFA-PM-92-2 (HSQB)
MARCH 1992

State: MINNESOTA

Citation 4.41 Resident Assessment for Nursing Facilities

Sections 1919(b)(3) and 1919(e)(5) of the Act; 42 CFR §483.315(a)

(a) The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b)(3)(A) of the Act.

§1919(e)(5)(A) of the Act and 42 CFR §483.315(b)(1)

(b) The State is using:

_x_ the resident assessment instrument designated by the Health Care Financing Administration, and issued (and updated) by HCFA in the State Operations Manual (HCFA Pub. 7) [§1919(e)(5)(A)]; or

§1919(e)(5)(B) of the Act and 42 CFR §483.315(b)(2)

___ a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [§1919(e)(5)(B)].

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Minnesota

Citation 1902(a)(68) of the Act, P.L. 109-171 (section 6032)

4.42 Employee Education About False Claims Recoveries.

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Minnesota

health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Minnesota

(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(4) The requirements of this law should be incorporated into each State's provider enrollment agreements.

(5) The State will implement this State Plan amendment on January 1, 2007.

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Minnesota

Citation	
1902(a)(69) of the Act, (section 6034) P.L. 109-171	4.43 Cooperation with Medicaid Integrity Program Efforts. The Medicaid agency assures it complies with the Medicaid Integrity Program established under section 1936 of the Act, and that it will comply with any requirements of the Medicaid Integrity Program issued by the Secretary in accordance with the law.

Medicaid State Plan Preprint

State/Territory: Minnesota

PROPOSED SECTION 4 – GENERAL PROGRAM ADMINISTRATION

4.44 Medicaid Prohibition on Payment to Institutions or Entities Located Outside of the United States

Citation

Section 1902(a)(80) of the Social Security Act, P.L. 111-148 (Section 6505)

x The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

TN No. 11-21
Supersedes
TN No.

Approval Date: OCT 14 2011

Effective Date: 7/26/11

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: MINNESOTA

4.46 Provider Screening and Enrollment

Citation	
1902(a)(77) 1902(a)(39) 1902(kk); P.L. 111-148 and P.L.111-152	The State Medicaid agency gives the following assurances:
42 CFR 455	PROVIDER SCREENING
Subpart E	X Assures that the State Medicaid agency complies with the process for screening providers under sections 1902(kk), 1902(a)(39) and 1902(a)(77) of the Act.
42 CFR 455.410	ENROLLMENT AND SCREENING OF PROVIDERS
	X Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq.
	X Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.
42 CFR 455.412	VERIFICATION OF PROVIDER LICENSES
	X Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.
42 CFR 455.414	REVALIDATION OF ENROLLMENT
	X Assures that providers will be revalidated regardless of provider type at least every 5 years.
42 CFR 455.416	TERMINATION OR DENIAL OF ENROLLMENT
	X Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.

4.46 Provider Screening and Enrollment, continued

42 CFR 455.20 REACTIVATION OF PROVIDER ENROLLMENT

X Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

42 CFR 455.422 APPEAL RIGHTS

X Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.

42 CFR 455.432 SITE VISITS

X Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high" risk categories will occur.

42 CFR 455.434 CRIMINAL BACKGROUND CHECKS

X Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.

42 CFR 455.436 FEDERAL DATABASE CHECKS

X Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

42 CFR 455.440 NATIONAL PROVIDER IDENTIFIER

X Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

4.46 Provider Screening and Enrollment, continued

42 CFR 455.450 SCREENING LEVELS FOR MEDICAID PROVIDERS

X Assures that the State Medicaid agency complies with 1902(2)(77) and 1902 (kk) of the Act and with the requirements outlined in 42 CFR 455.40 for screening levels based upon the categorical risk level determined for a provider.

42 CFR 455.460 APPLICATION FEE

X Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.

42 CFR 455.470 TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS

X Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Minnesota

4.47 21ST CENTURY CURES ACT – Section 5006:

"Requiring Publication of Fee-for-Service Provider Directory"

X State is in compliance with the requirements of Section 5006 of the 21st Century Cures Act.

☐ State will be in compliance with Section 5006 of the 21st Century Cures Act by _____.

☐ State Plan's managed care coverage exempts this state from the requirements of Section 5006 of the 21st Century Cures Act.

☐ State would potentially need to enact legislation to comply with Section 5006 of the 21st Century Cures Act and will discuss compliance with CMS.

STANDARDS FOR INSTITUTIONS

The following, available to the Health Care Financing Administration, is the list of state administrative rules governing health and other standards for private or public institutions that provide service to Medicaid recipients.

1. Minnesota Rules, part 4638.0200. This rule requires hospitals, nursing homes, boarding care homes, and supervised living facilities licensed by the Minnesota Department of Health to establish written policies specifying whether or not pet animals will be allowed on the premises. It establishes requirements that must be met by pets other than fish.

2. Minnesota Rules, chapter 4640. This chapter provides hospital standards for:

   (a) licensing
   (b) administration, medical staff, and personnel
   (c) records and reports
   (d) laboratory and x-ray services
   (e) accommodations, furnishings, and equipment for care
   (f) food service and food sanitation
   (g) the physical plant

3. Minnesota Rules, chapter 4645. This chapter provides standards for hospital construction and equipment.

4. Minnesota Rules, chapter 4650. This chapter provides hospital and surgical center standards for:

   (a) financial, utilization, and services data
   (b) administrative procedures for submitting reports
   (c) fees and fines

5. Minnesota Rules, chapter 4655. This chapter provides boarding care home standards for licensure, and establishes procedures for exceptions to the nursing home bed moratorium. In addition, this chapter sets out standards for boarding care home:

   (a) administration and personnel
   (b) records and reports
   (c) resident relocation
   (d) records of residents' and patients' funds
   (e) care of patients and residents
   (f) furnishings and equipment
   (g) linen service & laundry requirements; dietary service & sanitation; housekeeping
   (h) medication

STANDARDS FOR INSTITITIONS (continued)

6. Minnesota Rules, chapter 4656. This chapter provides Medicaid standards for:

   (a) review of care and classification of residents in Medicaid facilities; includes resident assessment
   (b) case mix reimbursement classifications

7. Minnesota Rules, chapter 4658. This chapter provides nursing home standards for:

   (a) licensure
   (b) administration and operations
   (c) resident personal funds accounting and records
   (d) restraints
   (e) resident assessments and plans of care
   (f) clinical records
   (g) nursing services
   (h) dietary service; medical and dental services; barber and beauty services
   (i) infection control
   (i) recreational programs
   (j) rehabilitative services
   (k) medications
   (l) environmental services (physical environment, resident units, plant housekeeping, solid waste disposal)
   (m) relocation of residents
   (n) physical plant licensure & new construction plans
   (o) mechanical & electrical systems

8. Minnesota Rules, chapter 4660. This chapter provides standards for the physical plant of boarding care homes.

9. Minnesota Rules, parts 9520.0500 through 9520.0670, which provide standards for the licensing of residential programs for adult mentally ill persons.

10. Minnesota Rules, parts 9520.0750 through 9520.0870, which provide standards for the administration of mental health center and mental health clinics.

11. Minnesota Rules, part 9525.0215 through 9525.0355, which provide standards for the licensing of resident programs for persons with mental retardation or related conditions (MR/RC). The rules provide minimum standards governing operation of residential programs.

STANDARDS FOR INSTITUTIONS (continued)

12. Minnesota Rules, chapter 9549. This chapter establishes procedures for determining the payment rates for nursing facilities participating in Medicaid, but also provides for resident classes (A through K) based upon resident assessment.

Due to the discressionary requirement as to the method an Intermediate Care Facility may use in meeting the requirement of 42 CFR 456.401 the State has allowed self determination by the facility to meet utilization review requirements in any one of the following methods.

1. The facility may contract with another facility in the area which has a utilization review committee for the services which meets the federal requirements.

2. The facility may contract with an organization qualified to perform the function of utilization review on behalf of the facility. To qualify, the organization must meet all the requirements in the federal regulations.

3. The facility may establish its own utilization review plan to conform to the requirements of the federal regulations.

When the Survey Agency surveys the facility, the determination of method is identified and the survey agency has the responsibility to determine if the facility qualifies for participation in the program. This qualification includes the factor of compliance with utilization review requirements.

STATE: MINNESOTA

Effective: October 1, 1995
TN: 95-39
Approved: 1/3/96
Supersedes: 94-29

ATTACHMENT 4.16-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

COOPERATIVE AGREEMENTS WITH DEPARTMENT OF HEALTH AND THE CHILD SUPPORT ENFORCEMENT DIVISION AND WITH TITLE V GRANTEES

The current numbered agreements comprising Attachment 4.16-A to the State Plan remain in effect.

Agreement #1	Agreement with the Title V grantees - Maternal and Child Health Services
Agreement #2	Agreement with the Department of Health for certification and inspections of ICFs and NFs
Agreement #3	Agreement with the Department of Health for Program Development, Training, and Evaluation of Child and Teen Checkup Services.
Agreement #4	Cooperative Agreement between Health Care Programs and Child Support Enforcement Division
Agreement #5	Interagency Agreement with Department of Jobs and Training

HCFA-179 # _____ Date Rec'd _____
Supercedes _____ Date Appr. _____
State Rep. In _____ Date Eff. _____

STATE OF MINNESOTA

INTERAGENCY MEMORANDUM OF UNDERSTANDING

WHEREAS, the Minnesota Department of Health is responsible for administrating the Title V program pursuant to Minnesota Statutes, section 145.88; and

WHEREAS, the Department of Human Services is responsible for administrating the Medicaid program pursuant to Minnesota Statutes, section 256.01, subdivision 2, paragraph (1), and 256B.04, subdivision 1; and

WHEREAS, the Department of Human Services and the Department of Health are committed to promoting quality health care services for low-income children, pregnant women and children with special health care needs, including primary and preventive health services; and

WHEREAS, the Department of Health and the Department of Human Services are interested in coordinating and enhancing efforts, streamlining application processes, reducing duplicative efforts, and ensuring compliance with federal and state laws and regulations and the appropriate use of public funds:

NOW, THEREFORE, it is agreed:

I. Duties of the Department of Human Services. The Department of Human Services shall:

A. Participate as requested on Department of Health advisory or work groups related to maternal and child health issues including children with special health care needs.

B. Participate in quarterly joint meetings. Membership shall consist of the Medicaid Director or a designee and at least three additional appointees from the Department of Human Services. Purpose of the meetings to include:

1. Coordinate departmental policies/procedures that impact health care services or the delivery of health care services to the maternal and child health populations.

2. Identify annually at least one issue related to maternal or child health or children with special health care needs for joint departmental focus.

3. Identify how the departments can work together to identify individuals under 21 in need of medical or remedial services.

4. Identify areas where the departments could share or maximize staff expertise.

5. Share appropriate and relevant aggregate data affecting health status or the delivery of health care services to the maternal and child health population and children with special health care needs.

6. Review at least annually this Memorandum of Understanding and determine if any changes are required.

STATE: MINNESOTA Enter into separate Interagency Agreements for those duties that require a transfer of personally identifying data and funds.

D. Accept referrals from the Department of Health for the Medical Assistance and MinnesotaCare program.

Duties of the Department of Health. The Department of Health shall:

A. Participate as requested on Department of Human Services advisory or work groups related to maternal and child health issues including children with special health care needs.

B. Participate in quarterly joint meetings. Membership shall consist of the Title V Director or a designee and at least three additional appointees from the Department of Health. Purpose of the meetings to include:

1. Coordinate departmental policies/procedures that impact health care services or the delivery of health care services to the maternal and child health populations.

2. Identify annually at least one issue related to maternal or child health or children with special health care needs for joint departmental focus.

3. Identify how the departments can work together to identify individuals under 21 in need of medical or remedial services.

4. Identify areas where the departments could share or maximize staff expertise.

5. Share appropriate and relevant aggregate data affecting health status or the delivery of health care services to the maternal and child health population and children with special health care needs.

6. Review at least annually this Memorandum of Understanding and determine if any changes are required.

C. Enter into separate Interagency Agreements for those duties that require a transfer of personally identifying data and funds.

D. Accept referrals from the Department of Human Services and provide follow-up services to children with special health care needs and their families as requested.

II. TERMS OF AGREEMENT This agreement shall be effective on July 1, 2003, or upon the date that the final required signature is obtained, whichever occurs later, or until a revised agreement is signed.

III. CANCELLATION This agreement may be cancelled by either department at any time, with or without cause, upon thirty (30) days written notice to the other party.

IV. AUTHORIZED REPRESENTATIVES The Department of Health's authorized representative for the purposes of administration of this agreement is Janet Olstad. The Department of Human Services authorized representative for the purposes of administration of this agreement is Susan Castellano. Each representative shall have final authority for acceptance of services of the other party.

V. ASSIGNMENT Neither the Department of Health nor the Department of Human Services shall assign assign or transfer any rights or obligations under this agreement without the prior written consent of the other party.

VI. AMENDMENTS Any amendments to this agreement shall be in writing, and shall be executed by the same parties who executed the original agreement, or their successors in office.

VII. LIABILITY The Department of Health and the Department of Human Services agree that each party will be responsible for its own acts and the results thereof to the extent authorized by law and shall not be responsible for the acts of any others and the results thereof. The Department of Health and the Department of Human Services liability shall be governed by the provisions of the Minnesota Tort Claims Act, Minnesota Statutes, section 3.376, and other applicable law.

VIII. DATA PRACTICES ACT The Department of Health and the Department of Human Services agree to comply with the Minnesota Data Practices Act as it applies to all data provided by the other agency in accordance with this agreement and as it applies to all data created, gathered, generated or acquired in accordance with this agreement.

IX. JURISDICTION AND VENUE This agreement, and amendments and supplements thereto, shall be governed by the laws of the State of Minnesota. Venue for all legal proceedings arising out of this agreement, or breach thereof, shall be in the state or federal court with competent jurisdiction in Ramsey County, Minnesota.

IN WITNESS WHEREOF, the parties have caused this agreement to be duly executed intending to be bound thereby.

APPROVED:

Department of Health:	Department of Human Services:
By (authorized signature) Van Vernetti	By (authorized signature) Mary B Kenney
Title MCH Director	Title Medical Director
Date 8/11/03	Date 08/11/03

ADDENDUM TO ATTACHMENT 4.16-A
Agreement #1

☐ In accordance with 42 CFR §431.615(d)(5)(i), the Department contracts with counties to perform outreach and follow-up EPSDT services for EPSDT-eligible children. Specifically, in order to identify children under 21 in need of medical or remedial services, the Department receives screening and referral information from managed care health plans that is fed into the Department's "CATCH ~~H~~ 3" tracking system. This information is downloaded to the counties for use in performing outreach activities to families to encourage children to receive EPSDT screenings. It is also used for referral follow-up activities that assist families and children to receive needed services as a result of problems found during EPSDT screenings.

Because the Minnesota Department of Health is not a partner in the CATCH ~~H~~ 3 tracking system, these specifics are not made a part of the Interagency Memorandum of Understanding.

☐ In accordance with 42 CFR §431.615(d)(5)(iv), the Department contracts with the Minnesota Department of Health to provide training to providers. The health department trains nurses to conduct EPSDT visits and trains private Medicaid providers on EPSDT service requirements. Additionally, the health department responds to requests for specific trainings from any EPSDT provider in Minnesota. In sum, the Minnesota Department of Health provides technical assistance to Medicaid EPSDT providers.

STATE OF MINNESOTA
INTERAGENCY AGREEMENT
BETWEEN THE DEPARTMENTS OF
HUMAN SERVICES (DHS) AND HEALTH (MDH)

WHEREAS, the Minnesota Department of Human Services (hereinafter referred to as "DHS") and the Minnesota Department of Health (hereinafter referred to as "MDH") are empowered to enter into interagency agreements pursuant to Minnesota Statutes, §471.59, Subdivision 10; and

WHEREAS, DHS is the state agency responsible to help people meet their basic needs by providing or administering health care coverage for Minnesotans. DHS is also the single state agency responsible for administering and monitoring the state plan for Medical Assistance (hereinafter referred to as "MA") pursuant to 42 United States Code (USC), sec. 1396a; and

WHEREAS, DHS is the state agency responsible under 42 USC, sec. 1396a for ensuring that only qualified individuals can access MA and that federal financial participation be provided only for long-term care facilities meeting the requirements of participation in the Medicaid program outlined in 42 USC, sec. 1396r; and

WHEREAS, MDH is the state's official health agency responsible for the development and maintenance of an organized system of programs and services for protecting, maintaining, and improving the health of the citizens of Minnesota. MDH is also designated as the State Survey agency:

- under Section 1902(a)(33) of the Social Security Act (hereinafter referred to as the "Act"), responsible for determining whether facilities meet the requirements for participation in MA as nursing facilities (hereinafter referred to as "NFs"), intermediate care facilities for people with developmental disabilities (hereinafter referred to as "ICFs/DD") or nursing facility/institutions for mental diseases (hereinafter referred to as "NF/IMDs");
- under the Code of Federal Regulations 42 (CFR) 431.610 and 483.410 through 483.480, to implement and enforce these sections pertaining to compliance and complaint investigations of residential facilities that are certified by MDH as NFs or ICFs/DD;
- pursuant to Code of Federal Regulations 42 (CFR) 483.150-156 regarding nursing assistant training and competency evaluations and the establishment of a nursing assistant registry; and

WHEREAS, DHS and MDH have mutual and individual responsibilities relating to the **survey, licensure, certification, complaint investigations and enforcement of regulations** pertaining to Minnesota's residential care facilities, nursing assistant training and competency evaluation programs and maintenance of the nursing assistant registry; and

WHEREAS, the United States Department of Health and Human Services (hereinafter referred to as "HHS") has issued regulations concerning the survey and certification of NFs, ICFs/DD, and NF/IMDs, as required by Title XIX of the Act which imposes duties and responsibilities upon DHS and MDH. In order to fulfill these duties and responsibilities, DHS and MDH must delineate functions to be performed and the responsibilities of each agency with respect to the survey, certification and enforcement process for NFs, ICFs/DD and NF/IMDs participating in the Minnesota MA program; and

WHEREAS, MDH is responsible to conduct complaint investigations of ICFs/DD in accordance with 42 CFR §483.410 through §483.480 and Chapter 5 of the State Operations Manual (SOM).

WHEREAS, MDH is authorized by the HHS to carry out the provisions of Section 1864 of the Social Security Act, Title XVIII, which authorizes MDH to carry out the functions related to the survey and certification of providers; and

WHEREAS, the intent of this agreement is to achieve the goals of these programs and to comply with relevant state and federal regulations by delineating the functions to be performed and the responsibilities of DHS and MDH.

NOW, THEREFORE, it is agreed:

I. **MDH'S DUTIES:** MDH shall:

A. Coordinate with the DHS contract manager, the sharing of communications from the Centers for Medicare and Medicaid Services (CMS) that represent a change in policy or procedure with regards to the performance of contracted duties. MDH shall provide to DHS: copies of any written notices, letters or other documents received from CMS/HHS regarding these changes or with regards to state agency performance of duties and CMS State Agency performance results. For purposes of this agreement, MDH compliance with notification requirements shall be met if notice is provided to the designated contract manager.

B. Conduct surveys, licensure, certification and complaint investigations in accordance with federal requirements for NFs, ICFs/DD, and NF/IMDs to determine provider eligibility for participation in the MA program. The requirements specified in 42 CFR 431.610(f) and (g) and the survey and certification and enforcement regulations specified in 42 CFR 488.300-488.456 shall be complied with as part of the survey and compliance process. The implementation of these regulations shall be consistent with the MA State Plan.

C. Impose remedies as specified under federal law for facilities that do not meet the requirements of participation in the MA program. For those facilities where sanctions for non-compliance with MA requirements such as; termination, state monitoring, denial of payment, or the imposition of monetary penalties have been recommended or imposed, MDH shall concurrently notify the DHS contract manager and the facility of the remedy

imposed. MDH shall notify the DHS contract manager within two business days, in cases where a facility has been notified of an immediate jeopardy.

D. Routinely provide to DHS information obtained in any MDH review and/or survey of a NF, ICF/DD, or NF/IMD relative to noncompliance with the applicable rules, federal regulations or procedures.

E. Be responsible for collecting and providing to DHS data, reports and information related to: survey, certification and compliance, nursing assistant training and competency evaluation, the nursing assistant registry, and/or other activities covered under this agreement, as may be deemed useful and necessary by DHS. Data shall be provided in formats and according to schedules mutually agreed upon by DHS and MDH.

F. Provide to DHS, within available resources, policy consultation and/or support on issues related to the duties and provisions outlined in this agreement.

G. Be responsible for conducting periodic educational programs, within available resources, for the staff, residents (or their representatives), and representative provider organizations, to present current regulations, procedures and policies related to the survey, certification and enforcement process.

H. As a condition of this agreement, comply with action plans included in the annual survey and certification quality improvement report required under Minnesota Statutes, Section 144A.10, subdivision 17. MDH will notify the DHS contract manager when the annual report has been published on the MDH website.

I. Maintain records of all information and reports used in determining whether facilities meet federal requirements of participation. MDH shall retain information in accordance with federal and state records retention schedules.

J. MDH shall provide the DHS provider enrollment area summary information concerning certification of new providers, provider terminations and changes in facility bed count or ownership.

K. Designate state-approved nursing assistant competency evaluation programs for persons seeking employment in certified nursing facilities. MDH may contract with outside vendors for a statewide program to administer the state-approved competency evaluation program. MDH shall review any preliminary agreement with an outside vendor with the DHS contract manager prior to the final execution of the contract. MDH or its contractor shall review and re-approve nursing assistant training and competency evaluation programs at a frequency and using a methodology consistent with federal regulations. MDH shall establish procedures for and maintain the security of the state approved competency evaluation program.

L. Maintain a registry of individuals who have satisfactorily completed an approved nursing assistant competency evaluation program or an approved nursing assistant training

and competency evaluation program, in accordance with federal regulations.

M. The MDH Office of Health Facility Complaints shall conduct timely investigations of complaints regarding nursing facility resident abuse, neglect or misappropriation of resident property by a nursing assistant providing services in a nursing facility, in accordance with 42 CFR 488.335. MDH shall report each confirmed case of resident abuse, neglect or misappropriation of resident property by a nursing assistant to the Minnesota Nursing Assistant Registry within ten days of substantiation of the incident.

N. The MDH Office of Health Facility Complaints shall conduct an investigation of complaints regarding nursing facility resident abuse, neglect or misappropriation of resident property, by any other individual providing services in a nursing facility, in accordance with 42 CFR 488.335. MDH shall report each confirmed case of resident abuse, neglect or misappropriation of resident property by any other person providing services in a nursing facility, to the appropriate licensing authority, board or other authorities within ten days of substantiation of the incident.

II. DHS'S DUTIES: DHS shall:

A. Monitor the timeliness of physician certification in NFs, ICFs/DD, NF/IMDs, and of physician recertification plans in ICFs/DD.

B. Issue MA provider agreements to NFs, ICFs/DD, and NF/IMDs certified by MDH.

C. Routinely provide to MDH information obtained by any DHS audit process of a NF, ICF/DD, or NF/IMD relative to noncompliance with licensing and/or certification requirements.

D. Maintain a separate dedicated account for the collection and disbursement of civil monetary penalty (CMP) funds. DHS shall ensure that these funds are not intermingled with other department or state administrative or general funding and adhere to all federal requirements under 42 CFR 488 and Section 6111 of the Patient Protection and Affordable Care Act (Public Law 111-148). DHS shall ensure that all projects are approved by the federal CMS and pay for approved projects in a timely manner utilizing these funds.

III. JOINT AGENCY'S DUTIES:

A. MDH and DHS shall both, upon receipt of a complaint involving a facility that is certified as an ICF/DD facility, forward copies of the complaint to the other agency within one business day of receipt of the complaint. MDH and DHS agree that if both agencies are investigating the same complaint, investigative efforts, including site visits, will be coordinated to the extent possible and that at the conclusion of any such investigation, each agency shall forward to the other agency a copy of its findings, conclusions, determinations, and actions.

B. The Joint Civil Monetary Penalty (CMP) Committee, with DHS as the lead agency and operating in a manner consistent with CMS guidelines; consisting of representatives from DHS, MDH, the Office

of Ombudsmen for Long-Term care, and industry and public representatives as appointed by the Commissioner of MDH, shall make recommendations to CMS related to the implementation and use of the CMP funds.

IV. CONSIDERATION AND TERMS OF PAYMENT

A. **Quarterly Estimates.** MDH shall submit to DHS estimates for anticipated costs (federal share) for all survey, certification and other activities performed under this agreement. MDH shall submit to DHS estimates for the anticipated federal share of these costs on a quarterly basis, to be submitted no later than 55 days prior to the beginning of each quarter. For purposes of this contract, the term "quarter" shall mean a period of three months ending on the last day of March, June, September and December.

B. **Monthly Invoices.** MDH shall submit to DHS monthly invoices requesting the anticipated federal share needed only for that month's expenditures for the activities performed under this agreement. These estimates shall identify expenditures eligible for state and federal financial participation and must itemize costs at both the 50% and 75% rates of federal financial participation.

C. **Monthly Payments.** DHS will submit monthly payments to MDH based on these invoices within 10 days of receipt, up to the amount available as awarded by the federal awarding agencies. If federal awards are insufficient, DHS will make payments up to the federal funds available and make additional payments as federal awards are received.

D. **Non-Federal Share.** MDH shall provide the non-federal share of all expenditures for which federal revenue is claimed. In addition, MDH shall ensure that all non-federal matching funds shall be from sources other than federal funds or funds used to match other federal funds.

E. **Expenditure Reports and Reconciliation of Expenditures.** MDH is responsible to prepare and submit to CMS, all required accrual based quarterly expenditure, revised expenditure, and final reconciliation reports. These reports shall include all costs attributable to MDH in order to carry out the functions of this agreement, but shall exclude the costs of licensing activities. The reports shall be prepared in compliance with all applicable federal regulations and requirements including: Title XIX of the Social Security Act, Code of Federal Regulations Titles 42 and 45, OMB Circular A-87 Cost Principles For State, Local and Indian Tribal Governments, budget and accounting standards adopted by the State, and applicable provisions contained within the State Medicaid manual, to ensure that costs claimed for federal reimbursement shall be accurate and reflect actual costs incurred only for the services provided under this agreement. These expenditure reports shall identify expenditures eligible at both the 50% and 75% rates of federal financial participation and shall be submitted to CMS in a timely manner. MDH is responsible to maintain the documentation for these reports. MDH shall furnish or make available information on any accounts, expenditures or reports as requested by the DHS contract manager or any other entity acting on behalf of DHS, for the purposes of auditing and review.

F. **Notice of Expenditures.** Annually at the end of the federal fiscal year, MDH shall prepare and submit to the DHS contract manager a final notice of all federal and state expenditures made during the federal fiscal year for the survey, certification and other activities performed under this agreement. Upon request biannually, MDH shall prepare and submit to the DHS contract manager a notice of estimated

federal and state expenditures for both the federal and state fiscal years for the survey, certification and other activities performed under this agreement.

G. **Revised Expenditures.** DHS will make additional payments to MDH, if necessary and to the extent federal awards are available, based on either the reconciliation or revised expenditure reports that MDH submits to CMS. If overpayments have been made for the prior operating year, based on the final reconciliation conducted by MDH, MDH shall refund the overpayment to DHS within 5 business days from the date the accounting codes are provided by DHS to MDH.

H. **CMP Projects.** DHS shall transfer funds to MDH for approved CMP projects where MDH is the lead agency. Upon project completion, MDH shall submit to DHS all required proof of expenses and required documentation. Upon project completion, MDH shall transfer any unspent monies back to the DHS CMP fund account.

I. **Payment upon Termination of Agreement.** If this agreement is terminated, any funds paid to MDH under this agreement that have not been expended in accordance with the provisions of this agreement before the due date of termination and any property purchased with funds paid to MDH under provisions of this agreement, shall be accounted for in accordance with standards established by the State of Minnesota governing disposition of such property and funds.

V. CONDITIONS OF PAYMENT All services provided by MDH pursuant to this agreement shall be performed to the satisfaction of DHS, as determined at the sole discretion of its authorized representative.

VI. TERMS OF AGREEMENT This agreement shall be effective on **July 1, 2013** or upon the date that the final required signature is obtained, pursuant to Minnesota Statutes, Section 16C.05, Subd 2, whichever occurs later and shall remain in effect until **June 30, 2015**, or until all obligations set forth in this agreement have been satisfactorily fulfilled, whichever occurs first.

VII. CANCELLATION This agreement may be canceled by DHS or MDH at any time, with or without cause, upon thirty (30) days written notice to the other party. In the event of such a cancellation, MDH shall be entitled to payment, determined on a pro rata basis, for work or services satisfactorily performed.

VIII. AUTHORIZED REPRESENTATIVES DHS's authorized representative for the purposes of Administration of this agreement is Robert Held, Director of the Nursing Facility Rates and Policy (NFRP) Division or his successor. MDH's authorized representative for the purposes of administration of this agreement is Susan Winkelmann, Assistant Director of the Division of Compliance Monitoring or her successor. MDH hereby designates **Thomas S. Johnson**, Director of Budget and Operations for the Compliance Monitoring Division or his successor/s in office, as MDH Contract Manager for the responsibility of administering this interagency agreement and monitoring compliance with provisions contained herein. DHS hereby designates **Munna Yasiri**, State Programs Administrator Director or her successor/s in office, as DHS Contract Manager for the responsibility of administering this interagency

agreement, monitoring compliance with provisions contained herein, for the administration of the CMP fund and committee, as liaison to CMS, and for compliance with applicable regulations. These persons and/or their designees and successors in office shall schedule and hold meetings on a semi-annual basis to discuss the activities covered by this agreement. Each representative shall have final authority for acceptance of services of the other party and shall have responsibility to insure that all payments due to the other party are made pursuant to the terms of this agreement.

IX. ASSIGNMENT Neither MDH nor DHS shall assign or transfer any rights or obligations under this agreement without the prior written consent of the other party.

X. AMENDMENTS Any amendments to this agreement shall be in writing, and shall be executed by the same parties who executed the original agreement, or their successors in office.

XI. LIABILITY The parties agree that each party will be responsible for its own acts and the results thereof to the extent authorized by law and shall not be responsible for the acts of the other and the results thereof. Each party's liability shall be governed by the provisions of the Minnesota Tort Claims Act, Minnesota Statutes, Section 3.736, and other applicable law.

XII. INFORMATION PRIVACY PROTECTION

For purposes of executing its responsibilities and to the extent set forth in this agreement, MDH will be considered part of the "welfare system," as defined in Minnesota Statutes §13.46, subdivision 1. The MDH's employees and agents will have access to private or confidential data maintained by DHS only to the extent necessary to carry out the responsibilities under this agreement. Both agencies agree to comply with all relevant requirements of the Minnesota Government Data Practices Act (hereinafter "Data Practices Act," Minnesota Statutes, Chapter 13) in providing services under this agreement. MDH's representative or his/her successor is the responsible authority in charge of all data collected, used, or disseminated by DHS in connection with the performance of this agreement. DHS's representative or his/her successor is the responsible authority in charge of all data collected, used, or disseminated by DHS in connection with the performance of this agreement. See Minnesota Statutes section 13.46, subdivision 10.

Duty to ensure proper handling of data: MDH and DHS shall be responsible for training their respective employees who are authorized to access and use the data collected and used under the terms and for the purposes specified in this agreement. This responsibility includes ensuring that staff is properly trained regarding:

- The Minnesota Government Data Practices Act (MGDPA), Minnesota Statutes Chapter 13, and in particular, §13.46 ("welfare data");
- The Minnesota Health Records Act, Minn. Stat. §§144.291-144.298;
- Federal law and regulations that govern the use and disclosure of substance abuse treatment records, 42 USCS § 290dd-2 and 42 CFR § 2.1 to § 2.67;
- The Health Insurance Portability Accountability Act ("HIPAA"), 45 CFR Parts 160 and 164 (if ap

plicable);

- Electronic Health Records (as governed by Health Information Technology for Economic and Clinical Health Act (HITECH), 42 USC 201 note, 42 USC 17931); and
- Any other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information.

Minimum necessary access to data:
The MDH and DHS shall comply with the "minimum necessary" access and disclosure standards set forth in the Data Practices Act. The dissemination of "private" and/or "confidential" data on individuals is limited to "that necessary for the administration and management of programs specifically authorized by the legislature or local governing body or mandated by the federal government." *See* Minnesota Statutes, §13.05, subd. 3.

MDH and DHS shall:
(1) Not use or further disclose the information other than as permitted or required for the administration of this agreement or as required by law;
(2) Make its internal practices, books, records, policies, procedures, and documentation relating to the use, disclosure, and/or security of information available to the other agency and/or the Secretary of the HHS for purposes of determining compliance with all applicable regulations;
(3) Document disclosures of protected information and provide this information to the other agency as would be required for the other agency to respond to a request for an accounting of such disclosures;
(4) Obtain any required consents, authorizations or other permissions that may be necessary for it to share information with the other agency, and notify the other agency of any limitation(s), restrictions, changes, or revocation of permission to use or disclose such information;
(5) Use appropriate safeguards to prevent use or disclosure of the information by its employees other than as provided for by this agreement;
(6) Report any use or disclosure of the information not provided for by this agreement of which it becomes aware;
(7) Consistent with this agreement, ensure that any agents (including contractors and subcontractors), analysts, and others to whom it provides private or confidential data, agree to be bound by the same restrictions and conditions that apply to them with respect to such information;
(8) Upon completion, expiration or termination of this agreement, return or destroy all protected information received from the other agency, unless return or destruction is not feasible. If return or destruction is not feasible, each agency will extend the protections of this agreement to the information collected during the course of this agreement.

Release of data
No private or confidential data created, collected, received, stored, used, maintained or disseminated in the course or performance of this agreement will be disseminated except as authorized by statute, either during the period of this agreement or hereafter. Each party shall be independently responsible for compliance with any requirements of the Health Insurance Portability Accountability Act ("HIPAA," 45 CFR §§160 and 164), and neither party will be liable for any violation of any provision of HIPAA indirectly or directly arising out of, resulting from, or in any manner attributable to actions of the other party or its employees or agents.

The MDH and DHS agree that each is independently responsible for complying with the Minnesota Data Practices Act, Minnesota Statutes Chapter 13, and that each party will be responsible for its own acts

and those of its employees and the results thereof to the extent authorized by law and shall not be responsible for the acts of the other party or its employees, or the results thereof.

XIII. This agreement shall be read in a manner consistent with Title XIX of the Social Security Act and with Minnesota Statutes Chapters 256B, 144 and 144A, and the regulations and rules promulgated thereunder, and with other policy and directives issued by HHS.

XIV. OTHER PROVISIONS

None.

IN WITNESS WHEREOF, the parties have caused this contract to be duly executed intending to be bound thereby APPROVED:

1. STATE ENCUMBRANCE VERIFICATION
Individual certifies that funds have been encumbered as required by Minn. Stat. §§ 16A.15 and 16C.05

By: N/A

Date:

CFMS Contract No: N/A

2. MDH

By:
(with delegated authority)

Title: Accounting Director

Date: 6/11/2013

3. DHS

By:
(with delegated authority)

Title: CFO/COO

Date: 6/21/13

Distribution:
DHS
MDH
DHS - Contracts Section

Contract IAK%62181

STATE OF MINNESOTA
INTERAGENCY AGREEMENT
BETWEEN THE DEPARTMENTS OF
HUMAN SERVICES (DHS) AND HEALTH (MDH)

WHEREAS, the Minnesota Department of Human Services (hereinafter referred to as "DHS") and the Minnesota Department of Health (hereinafter referred to as "MDH") are empowered to enter into interagency agreements pursuant to Minnesota Statutes, §471.59, Subdivision 10; and

WHEREAS, DHS is the state agency responsible to help people meet their basic needs by providing or administering health care coverage for Minnesotans. DHS is also the single state agency responsible for administering and monitoring the state plan for Medical Assistance (hereinafter referred to as "MA") pursuant to 42 United States Code (USC), sec. 1396a; and

WHEREAS, DHS is the state agency responsible under 42 USC, sec. 1396a for ensuring that only qualified individuals can access MA and that federal financial participation be provided only for long-term care facilities meeting the requirements of participation in the MA program outlined under 42 USC, sec. 1396r; and

WHEREAS, MDH is the state's official health agency responsible for the development and maintenance of an organized system of programs and services for protecting, maintaining, and improving the health of the citizens of Minnesota. MDH is also designated as the State agency:

- under Section 1902(a)(33) of the Social Security Act (hereinafter referred to as the "Act"), responsible for determining whether facilities meet the requirements for participation in MA as nursing facilities (hereinafter referred to as "NFs"), intermediate care facilities for people with developmental disabilities (hereinafter referred to as "ICFs/DD") or nursing facility/institutions for mental diseases (hereinafter referred to as "NF/IMDs"); and
- pursuant to Minnesota Statutes, Section 144.0724 to establish, administer and review resident reimbursement classifications, is responsible for the development and maintenance of the MDS tool which is used to determine Minnesota MA nursing home reimbursement rates, serves as the repository for this data; and

WHEREAS, DHS and MDH have mutual and individual responsibilities relating to the **Case Mix review program** which assesses resident level of care and is used to determine NF reimbursement rates and the **review of NF/IMDs** to determine their eligibility to receive federal funding under the MA program; and

WHEREAS, the intent of this agreement is to achieve the goals of these programs and to comply with relevant state and federal regulations by delineating the functions to be per-

formed and the responsibilities of DHS and MDH in the case mix program and the review of NF/IMDs.

NOW, THEREFORE, it is agreed:

I. **MDH'S DUTIES:** MDH shall:

A. Coordinate with the DHS contract manager, the sharing of communications that represent a change in policy or procedure with regards to the performance of contracted duties. MDH shall provide to DHS: copies of any written notices, letters or other documents regarding these changes or with regards to state agency performance of duties. For purposes of this agreement, MDH compliance with notification requirements shall be met if notice is provided to the contract manager or their designee.

B. Establish and implement resident reimbursement classifications in accordance with Minnesota Statutes 144.0724 and 256B.438.

C. Maintain a case mix review system based on the federally required Minimum Data Set (MDS) and upgrade as needed to ensure compliance with the latest version of the MDS. Develop software programs using the MDS 3.0, to perform all data extraction, classification, notification, review, and audit functions required for the determination of nursing home rates and the transmission of this data to DHS. Maintain an electronic archival system of all case mix manuals, case mix policies, procedures and forms documenting and dating any changes and making all archival documents available to DHS upon request.

D. Conduct audits of resident reimbursement classifications, pursuant to Minnesota Statutes, Section 144.0724, subd. 9.

E. Conduct NF Quality Indicator (QI) audits.

F. Conduct up to 16 NF reviews annually of NF/IMDs or potential NF/IMDs identified by DHS. These reviews will utilize IMD classification criteria.

G. Be responsible for collecting and providing to DHS data, reports and information related to: case mix resident reimbursement classifications, Minimum Data Set (MDS), Quality Improvement/Quality Measures, and the NF/IMD review process, and/or other activities covered under this agreement, as may be deemed useful and necessary by DHS. Data shall be provided in formats and according to schedules mutually agreed upon by DHS and MDH. This data shall be utilized to develop outcome and performance measurements, administer contracts for services as mandated by Minnesota Statutes 256B.434 and otherwise determine value, results, and outcomes for long-term care purchasing and determine eligibility for participation in the MA program. MDS data sharing shall be in accordance with the CMS/MDH/DHS Data Use Agreement.

H. Provide staff in sufficient number (subject to budgetary limitations) and of composi-

tion and qualifications to ensure that the requirements of this agreement are met. If sufficient resources are not available to meet these staffing requirements, MDH shall notify DHS and a coordinated effort shall be made to obtain sufficient resources from the state legislature and/or CMS.

I. Provide to DHS, within available resources, policy consultation and/or support on issues related to the duties and provisions outlined in this agreement.

J. Be responsible for conducting periodic educational programs, within available resources, for the staff, residents (or their representatives), and representative organizations of facilities referred to in this agreement, to present current regulations, procedures and policies related to the case mix process.

K. Retain records of information in accordance with federal and state record retention schedules.

II. DHS'S DUTIES: DHS shall:

A. Designate up to 16 NF/IMDs or potential NF/IMDs to be reviewed annually by MDH. DHS will provide this information by October 1st of each year. Upon request, DHS will provide in-service training on IMD classification criteria to MDH staff assigned to perform these reviews.

B. Inform the MDH case mix staff of issues concerning the payments file provided by MDH or other issues requiring investigation by MDH staff.

III. CONSIDERATION AND TERMS OF PAYMENT

A. **Quarterly Estimates.** MDH shall submit to DHS estimates for anticipated costs (federal share) for all MDS, quality assurance review and other activities performed under this agreement. MDH shall submit to DHS estimates for the anticipated federal share of these costs on a quarterly basis, to be submitted no later than 55 days prior to the beginning of each quarter. For purposes of this contract, the term "quarter" shall mean a period of three months ending on the last day of March, June, September and December.

B. **Monthly Invoices.** MDH shall submit to DHS monthly invoices requesting the anticipated federal share needed for only that month's expenditures for the activities performed under this agreement. These estimates shall identify expenditures eligible for state and federal financial participation and must itemize costs at both the 50% and 75% rates of federal financial participation.

C. **Monthly Payments.** DHS will submit monthly payments to MDH based on these invoices within 10 days of receipt, up to the amount available as awarded by the federal awarding agencies. If federal awards are insufficient, DHS will make payments up to the federal funds available and make additional payments as federal awards are received.

D. **Non-Federal Share.** MDH shall provide the non-federal share of all expenditures for which federal revenue is claimed. In addition, MDH shall ensure that all non-federal matching funds shall be from sources other than federal funds or funds used to match other federal funds.

E. **Accrual Based Quarterly Expenditure Reports.** Following the end of each quarter, MDH shall submit accrual based quarterly expenditure reports to DHS. These reports shall include all costs attributable to MDH in order to carry out the functions of this agreement. The reports shall be prepared in compliance with all applicable federal regulations and requirements including: Title XIX of the Social Security Act, Code of Federal Regulations Titles 42 and 45, OMB Circular A-87 Cost Principles For State, Local and Indian Tribal Governments, and applicable provisions contained within the State Medicaid manual, to ensure that costs claimed for federal reimbursement shall be accurate and reflect actual costs incurred only for the services provided under this agreement. These expenditure reports shall identify expenditures eligible at both the 50% and 75% rates of federal financial participation and shall be submitted no later than twenty five (25) days following the end of each quarter.

F. **Preparation of Reports.** All estimated cost reports, actual expenditure reports and other reports shall be prepared in accordance with budget and accounting standards adopted by the State of Minnesota. MDH shall furnish or make available information on any accounts, expenditures or reports as requested by DHS or as may be necessary for audit purposes.

G. **Final Reconciliation of Expenditures.** Following the end of the federal fiscal year, MDH shall prepare and submit to DHS a final reconciliation of all expenditures to all payments received during that fiscal year for the activities performed under this agreement. DHS shall provide MDH copies of the federal quarterly award documents to facilitate this reconciliation. MDH shall submit this reconciliation report to DHS no later than 90 days following the end of the federal fiscal year.

H. **Revised Expenditures.** Revised expenditure reports can and shall be submitted by MDH when appropriate and in compliance with the regulations and requirements cited in Clause III.E. DHS will make additional payments to MDH, if necessary, based on either the final reconciliation or revised quarterly expenditure reports and to the extent federal awards are available. If overpayments have been made for the prior operating year, based on the final reconciliation, MDH shall refund the overpayment to DHS within 5 business days from the date the accounting codes are provided by DHS to MDH.

I. **Payment upon Termination of Agreement.** If this agreement is terminated, any funds paid to MDH under this agreement that have not been expended in accordance with the provisions of this agreement before the due date of termination and any property purchased with funds paid to MDH under provisions of this agreement, shall be accounted for in accordance with standards established by the State of Minnesota governing disposition of such property and funds.

V. CONDITIONS OF PAYMENT All services provided by MDH pursuant to this agreement shall be performed to the satisfaction of DHS, as determined at the sole discretion of its authorized representative.

VI. TERMS OF AGREEMENT This agreement shall be effective on **July 1, 2013** or upon the date that the final required signature is obtained by the MDH, pursuant to Minnesota Statutes, Section

16C.05, Subd 2, whichever occurs later and shall remain in effect until **June 30, 2015**, or until all obligations set forth in this agreement have been satisfactorily fulfilled, whichever occurs first.

VII. CANCELLATION This agreement may be canceled by DHS or MDH at any time, with or without cause, upon thirty (30) days written notice to the other party. In the event of such a cancellation, MDH shall be entitled to payment, determined on a pro rata basis, for work or services satisfactorily performed.

VIII. AUTHORIZED REPRESENTATIVES DHS's authorized representative for the purposes of administration of this agreement is Robert Held, Director of the Nursing Facility Rates and Policy (NFRP) Division or his successor. MDH's authorized representative for the purposes of administration of this agreement is Susan Winkelmann, Assistant Director of the Division of Compliance Monitoring or her successor. MDH hereby designates **Thomas S. Johnson,** Director of Budget and Operations for the Compliance Monitoring Division or his successor/s in office, as MDH Contract Manager for the responsibility of administering this interagency agreement and monitoring compliance with provisions contained herein. DHS hereby designates **Munna Yasiri,** State Programs Administrator Director or her successsor/s in office, as DHS Contract Manager for the responsibility of administering this interagency agreement, monitoring compliance with provisions contained herein, for the administration of the CMP fund and committee, as liaison to CMS and for compliance with applicable regulations. These persons and/or their designees and successors in office shall schedule and hold meetings on a semi-annual basis to discuss the activities covered by this agreement. Each representative shall have final authority for acceptance of services of the other party and shall have responsibility to insure that all payments due to the other party are made pursuant to the terms of this agreement.

IX. ASSIGNMENT Neither MDH nor DHS shall assign or transfer any rights or obligations under this agreement without the prior written consent of the other party.

X. AMENDMENTS Any amendments to this agreement shall be in writing, and shall be executed by the same parties who executed the original agreement, or their successors in office.

XI. LIABILITY The parties agree that each party will be responsible for its own acts and the results thereof to the extent authorized by law and shall not be responsible for the acts of the other and the results thereof. Each party's liability shall be governed by the provisions of the Minnesota Tort Claims Act, Minnesota Statutes, Section 3.736, and other applicable law.

XII. INFORMATION PRIVACY PROTECTION

For purposes of executing its responsibilities and to the extent set forth in this agreement, MDH will be considered part of the "welfare system," as defined in Minnesota Statutes §13.46, subdivision 1. The MDH's employees and agents will have access to private or confidential data maintained by DHS only to the extent necessary to carry out the responsibilities under this agreement. Both agencies agree to

comply with all relevant requirements of the Minnesota Government Data Practices Act (hereinafter

"Data Practices Act," Minnesota Statutes, Chapter 13) in providing services under this agreement. MDH's representative or his/her successor is the responsible authority in charge of all data collected, used, or disseminated by DHS in connection with the performance of this agreement. DHS's representative or his/her successor is the responsible authority in charge of all data collected, used, or disseminated by DHS in connection with the performance of this agreement. See Minnesota Statutes section 13.46, subdivision 10.

Duty to ensure proper handling of data: MDH and DHS shall be responsible for training their respective employees who are authorized to access and use the data collected and used under the terms and for the purposes specified in this agreement. This responsibility includes ensuring that staff is properly trained regarding:

- The Minnesota Government Data Practices Act (MGDPA), Minnesota Statutes Chapter 13, and in particular, §13.46 ("welfare data");
- The Minnesota Health Records Act, Minn. Stat. §§144.291-144.298;
- Federal law and regulations that govern the use and disclosure of substance abuse treatment records, 42 USCS § 290dd-2 and 42 CFR § 2.1 to § 2.67;
- The Health Insurance Portability Accountability Act ("HIPAA"), 45 CFR Parts 160 and 164 (if applicable);
- Electronic Health Records (as governed by Health Information Technology for Economic and Clinical Health Act (HITECH), 42 USC 201 note, 42 USC 17931);
- Minnesota Statutes §144.0721 related to assessments of care and services to NF residents, and
- Any other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information.

The DHS (State Medicaid agency) has entered into Data Use Agreement number 19717 with the Centers for Medicare and Medicaid Services (CMS), to facilitate administration of a federal health care program and which covers the sharing of data from the long-term care minimum data set (MDS).

Minimum necessary access to data:
The MDH and DHS shall comply with the "minimum necessary" access and disclosure standards set forth in the Data Practices Act. The dissemination of "private" and/or "confidential" data on individuals is limited to "that necessary for the administration and management of programs specifically authorized by the legislature or local governing body or mandated by the federal government." *See* Minnesota Statutes, §13.05, subd. 3.

MDH and DHS shall:
(1) Not use or further disclose the information other than as permitted or required for the administration of this agreement or as required by law;
(2) Make its internal practices, books, records, policies, procedures, and documentation relating to the use, disclosure, and/or security of information available to the other agency and/or the Secretary of the HHS for purposes of determining compliance with all applicable regulations;
(3) Document disclosures of protected information and provide this information to the other agency as would be required for the other agency to respond to a request for an accounting of such disclosures;
(4) Obtain any required consents, authorizations or other permissions that may be necessary for it to

share information with the other agency, and notify the other agency of any limitation(s), restrictions, changes, or revocation of permission to use or disclose such information;
(5) Use appropriate safeguards to prevent use or disclosure of the information by its employees other than as provided for by this agreement;
(6) Report any use or disclosure of the information not provided for by this agreement of which it becomes aware;
(7) Consistent with this agreement, ensure that any agents (including contractors and subcontractors), analysts, and others to whom it provides private or confidential data, agree to be bound by the same restrictions and conditions that apply to them with respect to such information;
(8) Upon completion, expiration or termination of this agreement, return or destroy all protected information received from the other agency, unless return or destruction is not feasible. If return or destruction is not feasible, each agency will extend the protections of this agreement to the information collected during the course of this agreement.

Release of data
No private or confidential data created, collected, received, stored, used, maintained or disseminated in the course or performance of this agreement will be disseminated except as authorized by statute, either during the period of this agreement or hereafter. Each party shall be independently responsible for compliance with any requirements of the Health Insurance Portability Accountability Act ("HIPAA," 45 CFR §§160 and 164), and neither party will be liable for any violation of any provision of HIPAA indirectly or directly arising out of, resulting from, or in any manner attributable to actions of the other party or its employees or agents.

The MDH and DHS agree that each is independently responsible for complying with the Minnesota Data Practices Act, Minnesota Statutes Chapter 13, and that each party will be responsible for its own acts and those of its employees and the results thereof to the extent authorized by law and shall not be responsible for the acts of the other party or its employees, or the results thereof.

XIII. This agreement shall be read in a manner consistent with Title XIX of the Social Security Act and with Minnesota Statutes Chapters 256B, 144 and 144A, and the regulations and rules promulgated thereunder, and with other policy and directives issued by HHS.

XIV. OTHER PROVISIONS
None.

IN WITNESS WHEREOF, the parties have caused this contract to be duly executed intending to be bound thereby APPROVED:

1. STATE ENCUMBRANCE VERIFICATION
Individual certifies that funds have been encumbered as required by Minn. Stat. §§ 16A.15 and 16C.05

By: N/A

Date:

CFMS Contract No: N/A

2. MDH

By: Dan Fichtl
(with delegated authority)

Title: Accounting Director

Date: 6/11/2013

3. DHS

By:
(with delegated authority)

Title: CFO/COO

Date: 6/21/13

Distribution:
DHS
MDH
DHS - Contracts Section

Agreement #4
TN: 86-105

COOPERATIVE AGREEMENT BETWEEN HEALTH CARE PROGRAMS AND OFFICE OF CHILD SUPPORT ENFORCEMENT

This Agreement has been made and entered into this 23rd day of September, 1986 by and between the Health Care Programs Division (hereinafter referred to as HCP) and the Office of Child Support Enforcement (hereinafter referred to as OCSE) both administrative units of the Minnesota Department of Human Services for the purpose of defining the responsibilities of the parties hereto for identifying legally liable third party resources (medical support) and securing the medical support from an absent parent for a child for whom an assignment of medical support rights has been executed under Title 42 Code of Federal Regulations (CFR) 433.146. This agreement shall be read in a manner consistent with Title XIX and Title IV-D of the Social Security Act and with Minnesota Statutes, Chapters 256, 256B, and section 518.171 and shall remain in effect until amended or cancelled according to section V of this agreement.

WHEREAS, the United States Department of Health and Human Services has promulgated regulations which require the child support enforcement agency to assist the Medical Assistance (MA) agency in obtaining medical support on behalf of certain MA recipients (section 1912 of the Social Security Act as amended by section 2367 of the Deficit Reduction Act, Title 45 Code of Federal Regulations s 306.2 - 306.4).

WHEREAS, the United States Department of Health and Human Services has promulgated regulations which require the MA agency to enter into a cooperative agreement for the enforcement of rights to and collection of third party benefits (Title 42, Code of Federal Regulations s 433.151).

WHEREAS, in accordance with the agreement, OCSE is the designated administrative unit of the State directed with the responsibility of medical support enforcement activities;

WHEREAS, HCP, under Minnesota Statute 256.01, subdivision 2(1), and 256B.04, subdivision 1, is the administrative unit of the State responsible for the administration of the Medical Assistance Program in Minnesota;

WHEREAS, the State of Minnesota may reduce expenditures for medical care under the Medical Assistance program by maximizing use of third party resources through such agreement;

NOW, THEREFORE, be it resolved that HCP and OCSE agree to perform the following duties in connection with the agreement:

I. HCP Responsibilities

A. Assignment of Medical Support, Title 42 Code of Federal Regulations 435.604

HCP shall require individuals, as a condition of eligibility for Medical Assistance, to assign their right to any medical support or other payments for medical care to the Minnesota Department of Human Services and to cooperate in the establishment of paternity and obtaining third party payments. The individual shall be required to cooperate with HCP and OCSE, in establishing the paternity of children of unmarried parents for whom the individual can legally assign rights. The individual shall also be required to cooperate in obtaining medical care support and medical care payments for himself or herself as well as any other person for whom the individual can legally assign rights.

B. HCP Referrals to OCSE

The county agency is responsible for the determination of Medical Assistance eligibility. The county Medical Assistance financial worker shall refer custodial parents, caretakers, and/or children who are applying for or are recipients of Medical Assistance to the county child support unit for the purpose outlined in Section II of this agreement. Referrals shall be accompanied by the following documents.

1. The assignment of medical support;
2. Referral to support and collections;
3. Good cause form;
4. Health Insurance Information Form; and
5. Court order, if applicable.

C. Monitoring and Collections

The monitoring of Medical Assistance claims and payments are the responsibility of HCP. HCP shall bill the insurance provider that is liable for medical services provided to MA recipients.

II. Responsibilities of OCSE

A. Gathering Information

1. Upon referral from the County Medical Assistance financial worker, the county office of child support enforcement shall obtain medical support information and provide this information to HCP for third party liability activities. The information shall include the following:

a. Name, address, and Social Security number of absent parent.

b. Name and address of the absent parent's place of employment.

c. The absent parent's insurance policy name(s) and number(s) which include spousal or dependent coverage.

d. Names of persons covered under the absent parent's health insurance.

2. The child support enforcement agency shall obtain the above information for those Medical Assistance cases for which an assignment of medical support is in effect. The child support enforcement agency shall relay this information to the MA agency.

B. Establish and Enforce Medical Support

OCSE shall establish and enforce medical support pursuant to Minnesota Statutes. OCSE shall attempt to enforce the court order when the non-custodial parent does not comply. OCSE shall attempt to collect medical support by instituting legal action as necessary.

C. Changes in Health Insurance Coverage

OCSE shall communicate to HCP any known change in absent parents health insurance coverage.

D. Lapse in Coverage

OCSE shall request employers and other groups offering health insurance that is being enforced to notify OCSE of lapses in health insurance coverage.

E. Paternity Actions

Upon referral from HCP, OCSE shall investigate and pursue the establishment of paternity for children born out of wedlock for whom the custodial parent or caretaker can legally assign rights to medical support.

III. Reimbursement

A. Funding

HCP shall reimburse OCSE for the administrative costs incurred as the result of medical support enforcement activities and the duties undertaken pursuant to this agreement. Reimbursement from HCP shall be limited to the cost of services not required to be provided under the Child Support Enforcement Amendments of 1984.

B. Incentive Payments

HCP shall make an incentive payment for collections and/or recovery of medical costs which are the direct result of actions taken by a political subdivision, a legal entity of the subdivision, such as a prosecuting or district attorney or friends of the court, or another state.

The incentive payment shall be equal to 15% of the amount collected and shall be made from the federal share of that amount.

IV. OCSE Administrative Requirements

A. OCSE Organizational Structure (reference 45 CFR 306.11(a))

The Minnesota Child Support Enforcement Program is supervised by the state and administered by the counties. The program has local offices in each county human service department, welfare department, or county Attorney's office.

B. Maintenance of Records

OCSE shall establish and maintain information concerning medical support activities in accordance with 45 CFR 302.15, Reports and Maintenance of Records.

C. Government Data Practices Act

For the purposes of executing its responsibilities under this agreement, OCSE and HCP are considered part of the welfare system as defined in Minnesota Statute section 13.46, subdivision 1. OCSE and HCP employees and agents shall have access to private data maintained by HCP and OCSE to the extent necessary to carry out responsibilities under this agreement. OCSE and HCP agree to comply with all the requirements of the Minnesota Government Data Practices Act in providing services under this agreement. The Commissioner, Department of Human Services or a designated representative, is the authority in charge of all data collected, used or disseminated by HCP or OCSE in connection with the performance of this agreement. OCSE and HCP accepts responsibility for providing adequate supervision and training of its agents and employees to ensure compliance with the Act. No private or confidential data collected, maintained, or used in the course or performance of this agreement shall be disseminated except as authorized by statute, either during the period of this agreement or thereafter.

The use or disclosure of information concerning applicants for or recipients of medical support enforcement services is subject to the limitations in 45 CFR 303.21, Safeguarding Information.

D. Accountability

1. The local child support agency shall maintain an accounting system and supporting fiscal records adequate to assure that claims for reimbursement from the Medicaid agency are in accordance with applicable Federal requirements in 45 CFR Part 74, Administration of Grants.

2. A methodology shall be established for properly allocating those costs that cannot be directly charged to medical support activities.

V. Administration of Agreement

A. The Director of Health Care Programs and the Director of the Office of Child Support Enforcement are designated as the authorized agents responsible for the administration of this agreement.

B. Any changes in the terms or conditions of this agreement must receive the prior written approval of both parties.

C. This agreement may be cancelled by either party by providing sixty (60) days advance written notice to the other party of a specific date of termination.

IN WITNESS WHEREOF, the parties have caused this agreement to be executed intending to be bound thereby.

APPROVED:

HEALTH CARE PROGRAMS

By: Robert Baird

Title: Director

Date: 9/23/86

OFFICE OF CHILD SUPPORT ENFORCEMENT

By: [signature]

Title: Director

Date: 9/23/86

As To Form and Execution By The

ATTORNEY GENERAL

By: Patricia A. Somerby

Date: 9/23/86

INTERAGENCY AGREEMENT BETWEEN DEPARTMENT OF HUMAN SERVICES AND JOBS AND TRAINING

Whereas, the Department of Human Services (DHS) has received approval from the Health Care Financing Administration to reimburse vendors of day training and habilitation services licensed under Minnesota Rules, parts 9525.1500 to 9525.1690 using Medical Assistance (MA) funds for supported employment services (as defined in III B) to persons with mental retardation or related conditions in accordance with the criteria and definitions outlined below; and

Whereas, the Department of Jobs and Training, Division of Rehabilitation Services Vocational Rehabilitation Program (DRS/VR) also makes available supported employment services in accordance with Section 110 of the Rehabilitation Act of 1973 (29 USC 730) as amended in October of 1986 and delivered by vocational rehabilitation counselors; and

Whereas, regulations implementing section 9502(a) of P.L. 99-272 require that before MA funds can be used to reimburse supported employment services, the state certify that supported employment services are not otherwise available to an individual from DRS/VR under section 110 of the Rehabilitation Act of 1973 (29 USC 730); and

Whereas, Minnesota Statutes, sections 252.43 provides the Department of Human Services the authority to enter into agreements with the Department of Jobs and Training; and

Whereas, Minnesota Statutes, section 268.0122, subdivision 2 provides the Department of Jobs and Training the authority to contract with the Department of Human Services to carry out functions of implementation associated with employment and training programs;

NOW, THEREFORE, IT IS AGREED THAT:

I. The Department of Human Services and the Department of Jobs and Training agree to cooperate in determining individual eligibility for funding of a particular supported employment service in accordance with parts II, III, IV, V, VI and VII.

II. Applicability. The provisions contained in this agreement apply to local county social service agencies and county case managers of persons with mental retardation or related conditions and to local DRS/VR agencies.

III. Department of Human Services Duties. The Department of Human Services shall supervise local county social service agencies and shall assure that local county social service agencies comply with the following provisions. The following are actions required and criteria to be followed by county case managers of persons with mental retardation or related conditions when determining eligibility for and funding of a particular supported employment service:

A. Before supported employment services may be provided to persons with mental retardation or a related condition under the Home and Community-Based Waiver, a screening team convened in accordance with Minnesota Rules, parts 9525.0065 must determine that supported employment services are appropriate and that the person is eligible

for such services. Case managers must consult with the DRS/VR counselor or representative from the area vocational rehabilitation office as part of the assessment process prior to the screening. Attachment A, entitled Documentation of Eligibility For Supported Employment Services Under the Home and Community-Based Waiver And Client Choice Of Services, must be completed by the county case manager and signed by the county case manager and representative from the local DRS/VR agency. A copy of the form must be attached to the screening document submitted to the regional service specialist (RSS) for MA authorization. A copy of the completed form must also be included in the person's individual service plan file and a copy retained by the local DRS/VR agency or representative.

B. Supported employment services provided to a person with mental retardation or a related condition must be provided by a day training and habilitation services vendor licensed under Minnesota Rules, parts 9525.1500 to 9525.1690 and must meet the following criteria to be reimbursable under the Home and Community-Based Waiver:

1. The services are provided to an individual who resided in an ICF/MR or regional treatment center immediately prior to being served under the waiver and the person was discharged from the ICF/MR or regional treatment center on or after April 7, 1986.

2. The services are authorized by the case manager as part of an individual service/habilitation plan which includes residential services funded under the Home and Community-Based Waiver.

3. The services allow an individual 1) to engage in paid employment in a setting where persons without disabilities are also employed, particularly existing businesses or industry sites, and 2) the opportunity for social interactions with persons who do not have disabilities and who are not paid caregivers.

4. Public funds are necessary for the purpose of providing ongoing training and support services throughout the period of employment.

5. The person is not eligible for the particular supported employment service from a vocational rehabilitation program funded under Section 110 of the Rehabilitation Act of 1973 (29 USC 730) as amended in October of 1986 and delivered by DRS/VR. A finding that the person is not eligible for a particular service or that the needed services are not available from DRS/VR must be based on written documentation on forms supplied by the Commissioner of Human Services and filed with the individual service plan (see Attachment A).

C. When a person requires supported employment services and they are provided by a day training and habilitation services vendor licensed under Minnesota Rules, parts 9525.1500 to 9525.1690, the screening document (Attachment B), must be coded under Planned, Block 3, Item 12 (Adult day habilitation). "Supported Employment" must be written in Note Area 2 and also coded under Funding for Planned, Block 31, Item 12, as appropriate.

IV. Department of Jobs and Training Duties. The Department of Jobs and Training shall supervise local DRS/VR agencies that deliver supported employment services, and shall assure that local DRS/VR agencies comply with the following provisions.

A. Services to clients with a goal of supported employment are provided through agencies that provide specialized services which have been found through research and demonstration to result in paid employment. These specialized services include time-limited, intensive training at the actual job site by a job coach and other time-limited training for attainment of a supported employment outcome as agreed upon and specified for each client in the Individually Written Rehabilitation Program (IWRP). When the objectives of the IWRP have been met or it is determined that the person's optimal productivity level has been reached, long-term support will take effect and responsibility for funding, support, and case management will be assumed by the county social service agency.

B. When contacted by the county case manager of a person with mental retardation or a related condition, a representative of the local DRS/VR agency will cooperate with the county case manager to determine whether the person with mental retardation or a related condition is eligible for funding of a particular supported employment service under Section 110 of the Rehabilitation Act of 1973 as amended.

1. When the person is not eligible for reimbursement of a particular supported employment service under section 110 of the Rehabilitation Act of 1973, as amended, or the needed service is unavailable from DRS/VR, a representative of the local DRS/VR agency must document the client's ineligibility for DRS/VR funded services and co-sign the Documentation of Eligibility For Supported Employment Services Under the Home and Community-Based Waiver and Client Choice of Services.

2. A person's supported employment services must be delivered by DRS/VR in accordance with the following definitions and criteria to be reimbursable under Section 110 of the Rehabilitation Act of 1973 as amended:

a. Supported employment means employment of an individual who experiences a disability or disabilities severe enough to require ongoing training and support in order to retain and maintain employment in a position in which:

1) The individual engages in paid employment (typically for 20 or more hours a week) in a variety of integrated settings, particularly regular work sites; and

2) Public funds are necessary for the purpose of providing ongoing training and support services throughout the period of employment; and

3) There are opportunities for interactions with individuals who do not have disabilities and who are not paid caregivers.

3. Individual eligibility must be documented by a representative of the local DRS/VR agency in accordance with the following criteria:

   a. The presence of a physical or mental disability that is a substantial handicap to employment must be documented through evidence of a comprehensive diagnostic study with medical and/or psychological documentation of primary and any secondary disabilities; a description of how disability constitutes a vocational handicap; and the physical and/or psychological limitations are stated in functional terms.

   b. There must be a reasonable expectation that the provision of rehabilitation services will benefit the individual in terms of employability or that an extended evaluation is necessary in order to determine reasonable expectation of employability.

      1) Determine whether the employment resulting from the provision of rehabilitation services is likely to be supported employment or competitive.

      2) If the individual is likely to achieve supported employment, there must be a local agency/individual skilled in the provision of supported employment services from whom services can be purchased; and the county must agree to provide ongoing, perhaps lifetime, support services to insure that the individual will retain his/her job.

V. The date of effectiveness of this agreement is August 1, 1987. The agreement will remain in effect until amended or terminated.

VI. This agreement may be modified by mutual consent of the parties. Modifications to this agreement shall be in writing, and executed as an amendment to this contract.

VII. This agreement may be terminated by either party providing written notice is made 60 days in advance of termination.

VIII. The parties of this agreement agree to the provisions contained in Attachments A, B and C which are incorporated by reference and made part of this agreement.

10/26/87
Date

Department of Human Services

10/26/87
Date

Department of Jobs & Training

11-13-87
Date

Attorney General

Date

Administration

Date

Finance

ATTACHMENT A

DOCUMENTATION OF ELIGIBILITY FOR SUPPORTED EMPLOYMENT SERVICES UNDER THE HOME AND COMMUNITY-BASED WAIVER AND CLIENT CHOICE OF SERVICES

Person's Name_____
Person's MA ID#_____
Person's Birthdate_____

* If the person is age 21 or younger (or of school age according to state statute) the person is not eligible for supported employment services funded under the waiver.

I. Client Eligibility

Yes No

___ ___ Did this person exit directly from an ICF/MR into the Waivered Services Program on or after April 7, 1986?

* If no, the person is not eligible for supported employment services funded under the waiver.

___ ___ Will this person be receiving residential services funded under the waiver while receiving supported employment services?

* If no, the person is not eligible for supported employment services funded under the waiver.

___ ___ Have you coded DHS Form 2658 (Screening Document) "1" under Planned and Funding For Planned, Block 31, Item 12, (Adult Day Habilitation), and written "supported employment" in Note Area 2?

* If all of above are coded Yes, continue to next section.

II. Service Eligibility

The above-named individual must meet one of the criteria below to be eligible for funding of supported employment under the Home and Community-Based Waiver. This determination should be made in consultation with a Division of Rehabilitation Services/Vocational Rehabilitation (DRS/VR) counselor or representative.

Yes No

___ ___ The person is not considered an appropriate referral to DRS/VR in accordance with the screen-out criteria as described in Section 26520.025 of the Social Security Administration Program Operations Manual or presents an unfavorable applicant profile as described in section 26520.25 of the Social Security Administration Program Operations Manual (i.e., terminal degenerative disease).

OR

___ ___ The person has been referred to DRS/VR but was found to be ineligible.

OR

Yes No

___ ___ The person has been a recipient of supported employment services available under Section 110 but is no longer eligible for needed services because the objectives of the IWRP have been met, it was determined that the person's optimal productivity level had been reached, or because DRS/VR funds are not currently available to provide the necessary service.

OR

___ ___ The person is a current client of DRS/VR but the needed services are not available under Section 110.

Supported Employment Services
To Be Provided By Each Funding Source*

Funding	Service Type/Duration or Dates of Effectiveness
Waiver(MA)	
DRS/VR	

* Services typically available under section 110 may include, but are not limited to, time-limited services including on-the-job training, assessment, counseling, mobility training, transportation training, job development, and job placement. Services typically not available under section 110 may include, but are not limited to long-term services including ongoing support services, training in related skill areas essential to obtaining and retaining employment such as transportation, use of break areas, community resources, etc.

The above completed form constitutes an agreement, effective from _____ to _____, among the local county case manager, the vocational rehabilitation agency or representative, and the person who will receive services for the provision of the supported employment services specified above.

_____ _____
Date Signature of Case Manager

_____ _____
Date Signature of local DRS/VR Counselor or Representative

_____ _____
Date Signature of Person/Person's Legal Representative

* 1 copy in ISP file
1 copy to Regional Service Specialist
1 copy to local DRS/VR agency or representative

ATTACHMENT B
SCREENING DOCUMENT FOR INDIVIDUALS WITH MENTAL RETARDATION

DHS-7658
P2-/2668-01
(Effective 11-1-85)

(Consult Codebook for further explanation of items and codes)

CASE INFORMATION

Client Name — 1 LAST / FIRST / M

MA ID Number — 2

Case Number — 3

Date of Birth — 4 mmddyy

Sex — 5 (M / F)

Guardian Status — 6

1 = Has a private guardian (nonparent)
2 = Has a public guardian (Ward of Comm)
3 = Has a private conservator
4 = Has a public conservator
5 = Has a guardian "ad litem"
6 = Parent is legal guardian
7 = Needs guardian (full or limited)
8 = No guardian needed

County of: Fin Rsp — 7; Serv — 8; Resid — 9

MA Elig — 10

1 = Eligible
2 = Not eligible
3 = Holding document pending MA application
4 = Eligible by suspension of deeming rules

Case Manager Name — 11

CM Number — 12

QMRP Name — 13

Action Date — 14 mmddyy

Action Type — 15

01 = Initial Screening
02 = Unscheduled Rescreening
03 = Sched. Annual Rescreening
04 = Exit — no longer at-risk
05 = Exit — relocation
06 = Exit — loss of fin. elig.
07 = Exit — refuses services
08 = Exit — death
09 = Exit — other _____
10 = Re-entry screening
11 = Data collection

DIAGNOSTIC/ASSESSMENT RECORD

Medical — 16

1 = No serious/specialized medical needs
2 = Needs specialized or frequent medical attention (office visits only, not on-site attention)
3 = Needs on-call medical attention
4 = Needs on-site medical attention, but less than 24 hours day
5 = Needs on-site medical attention, 24 hours/day
9 = Unknown (justify in Note Area 1)

Vision — 17

1 = No impairment — normal function
2 = Difficulty at level of print
3 = Difficulty at level of obstacles
4 = No useful vision/blind
9 = Unknown (justify in Note Area 1)

Hearing — 18

1 = No impairment — normal function
2 = Loss present, no correction needed
3 = Impairment — correctable (with aid)
4 = Impairment — not correctable
5 = Only responds to alarm sounds
6 = No useful hearing/deaf
9 = Unknown (justify in Note Area 1)

Seizures — 19

01 = No history or evidence of seizures
02 = History of seizures, but none recently
03 = Occasional minor seizures — controlled
04 = Occasional minor seizures — uncontrolled
05 = Occasional major seizures — controlled
06 = Occasional major seizures — uncontrolled
07 = Frequent minor seizures — controlled
08 = Frequent minor seizures — uncontrolled
09 = Frequent major seizures — controlled
10 = Frequent major seizures — uncontrolled
99 = Unknown (justify in Note Area 1)

Mobility — 20

1 = No impairment — normal function
2 = Moves with assistance (walker, crutches, etc.)
3 = Moves with wheelchair — propelled by self
4 = Moves with wheelchair — propelled by others
5 = Not mobile due to overriding medical condition (please specify in Note Area 1)
9 = Unknown (justify in Note Area 1)

Commun — 21

1 = No impairment — normal function
2 = Speech is difficult to understand
3 = Uses sign language primarily
4 = Uses gestures and may use some signs
5 = Uses alternative communication devices
6 = Does not make needs known
9 = Unknown (justify in Note Area 1)

Self Preservation — 22

1 = Yes, is capable of self-preservation
2 = No, is not capable of self-preservation
3 = Unknown (justify in Note Area 1)

Lev of Supervision — 23

1 = Client is fully independent
2 = Client is semi-independent
3 = Client needs moderate supervision
4 = Client needs substantial supervision
5 = Client needs intensive supervision
9 = Unknown (justify in Note Area 1)

24 Behavior Problem Scales: (circle appropriate code — consult Codebook)

	None	Mild	Moder	Severe	Unkn
1. Withdrawl	1	2	3	4	9
2. Injurious to self	1	2	3	4	9
3. Physically injurious to others	1	2	3	4	9
4. Verbally abusive to others	1	2	3	4	9
5. Inapp. sexual behavior — self	1	2	3	4	9
6. Inapp. sexual behavior — others	1	2	3	4	9
7. Property destruction	1	2	3	4	9
8. Disruption of other's activities	1	2	3	4	9
9. Noncompliance/rebelliousness	1	2	3	4	9

25 ICD—9 Codes

Primary	Secondary	Tertiary

317 = mild mental ret.
318 = moderate mental ret.
318.1 = severe mental ret.
318.2 = profound mental ret.
319 = unspecified mental ret.

343 = cerebral palsy
345 = epilepsy
296 = psychosis
299 = autism

NOTE AREA 1:

26 Independent Living Skills — Level of Care Needed

1. Self Care
2. Toileting
3. Household Management
4. Money Management
5. Community Living
6. Leisure & Recreation

1 = Independent
2 = Minimal care needed
3 = Substantial care needed
4 = Total care & support needed
9 = Unknown (justify in Note Area 1)

(Continued on other side)

SCREENING INFORMATION

Team Convened (27): 1 2 — (1 = Yes, 2 = No)

Informed Choice Expl? (28): 1 2

Risk Status (29):

1 = Client is at-risk of ICF/MR placement
2 = Client is "at-risk" of ICF/II placement
3 = Client is "at-risk" of ICF/II placement
4 = Client is "at-risk" of SNF placement
5 = Client is in one of the risk groups in codes 1-4, but is not eligible for MA
6 = Client is not at-risk of placement in an ICF/MR, ICF, or SNF

30 Present at Screening

Client	Legal Rep	Cs Mangr	QMRP	Other
1 2	1 2	1 2	1 2	1 2

1 = Yes, present at screening
2 = No, not present at screening

SERVICES PLANNING (Consult Codebook for specific instructions, definitions)

31 Services	Current Yes	Current No	Planned Yes	Planned No	Funding for Planned: Waiver	Funding for Planned: Non-Waiver
(SUPPORT)						
1. Case Management	1	2	1	2	1	2
2. Homemaker Service	1	2	1	2	1	2
3. Respite Care/not ICF/MR bed	1	2	1	2	1	2
4. In-Home Family Support	1	2	1	2	1	2
5. Minor Physical Adapt	1	2	1	2	1	2
6. SLA — Child	1	2	1	2	1	2
7. SLA — Adult	1	2	1	2	1	2
8. Family Subsidy	1	2	1	2		
9. SILS	1	2	1	2		
10. Respite Care — ICF/MR (St Hosp)	1	2	1	2		
11. Respite Care — ICF/MR (Comm)	1	2	1	2		
(DAY)						
12. Adult day habilitation	1	2	1	2	1	2
13. Preschool program (home)	1	2	1	2		
14. Preschool program (center)	1	2	1	2		
15. Elem school program (public)	1	2	1	2		
16. Sec school program (public)	1	2	1	2		
17. Transition program	1	2	1	2		
18. Work activity (long term)	1	2	1	2		
19. Sheltered employ (long term)	1	2	1	2		
20. Protected work station	1	2	1	2		
(RESIDENTIAL)						
21. With bio/adopt family	1	2	1	2		
22. With relatives	1	2	1	2		
23. With foster family	1	2	1	2		
24. Own home — independent	1	2	1	2		
25. Own home — super ≤ 24 hours	1	2	1	2		
26. Own home — super 24 hours	1	2	1	2		
27. Licensed board and lodging	1	2	1	2		
28. Uncertified board and lodging	1	2	1	2		
29. ICF/MR — State Hospital	1	2	1	2		
30. ICF/MR — community	1	2	1	2		
31. ICF	1	2	1	2		
32. SNF	1	2	1	2		
33. Respite care facility	1	2	1	2		
34. Other	1	2	1	2		

NOTE AREA 2:

If ICF/MR — community, check box:

Class A ☐ Class B ☐

32 Special Support Services Needed	Yes	No
1. Specialized Medical Services	1	2
2. Physical Therapy	1	2
3. Occupational Therapy	1	2
4. Communication Training/Speech Therapy	1	2
5. Special Transportation	1	2
6. Behavior Management Program	1	2
7. Infant Stimulation	1	2

Cnty to Reside (33):

34 Preferred Choice of

Clnt/LR	Cs Mgr	QMRP

Final Action (35):

1 = Remain at home with waivered services
2 = Remain at home without waivered services
3 = Placement in community with waivered services
4 = Placement in community without waivered services but not in ICF/MR, ICF, or SNF
5 = Placement in ICF/MR — State Hospital
6 = Placement in ICF/MR Community
7 = Placement in an ICF
8 = Placement in an SNF
9 = Other (specify in Note Area 3)

Waiver Type (36):

1 = Diversion
2 = Conversion
3 = Client will not receive waivered services

NOTE AREA 3:

SIGNATURES

Case Manager _____ Date _____

QMRP _____ Date _____

Client/Legal Rep _____ Date _____

DHS _____ Date _____

RSS # _____

ATTACHMENT C

Interagency Agreement Between the Departments
of Human Services and Jobs and Training

For the purposes of executing its responsibilities, and to the extent set forth in this agreement, the Department of Jobs and Training shall be considered part of the welfare system as defined in Minnesota Statutes, section 13.46, subdivision 1. The Department of Jobs and Training employees and agents shall have access to private or confidential data maintained by the Department of Human Services to the extent necessary to carry out its responsibilities under the agreement. The Department of Jobs and Training agrees to comply with all the requirements of the Minnesota Government Data Practices Act in providing services under this agreement. James R. House, Director of Vocational Rehabilitation is the responsible authority in charge of all data collected, used, or disseminated by the Department of Jobs and Training in connection with the performance of this agreement. See Minnesota Statutes, Law 1984, chapter 436, section 24 amending Minnesota Statutes, section 13.46, subdivision 10. The Department of Jobs and Training accepts responsibility for providing adequate supervision and training to its agents and employees to ensure compliance with the Act. No private or confidential data collected, maintained, or used in the course of performance of the agreement shall be disseminated except as authorized by statute, either during the period of this agreement or thereafter. The Department of Jobs and Training agrees to indemnify and save and hold the state, its agents and employees, harmless from all claims arising out of, resulting from, or in any manner attributable to any violation of any provision of the Minnesota Government Data Practices Act, including legal fees and disbursements paid or incurred to enforce the provisions of this agreement.

LIENS AND ADJUSTMENTS OR RECOVERIES

1. The state uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

The State requests verification from the attending physician of the institutionalized individual's status immediately preceding giving notice of the State's intent to file a real property lien.

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR 433.36(f):

The State uses the following criteria:
*written proof verifying the date the son or daughter moved into the home;
*number of hours per day which the son or daughter provided on-site care, and personal care;
*any part-time or full-time jobs held while providing care;
*any schools or other similar institutions the son or daughter attended while providing care;
*specifics regarding the type of care the son or daughter provided, i.e., nursing care, daily living care, homemaker services, transportation, financial, etc.;
*any service agency, governmental or private, which provided care, the dates provided and the extent of the care provided;
*letter from the attending physician of the institutionalized individual, stating what kind of care, and duration of care, that was needed to prevent medical institutionalization;
*all other factors relevant to making the determination in a particular case.

3. The State defines the terms below as follows:

**estate* – For recipients deceased prior to August 1, 2003, estate is defined as used in Minnesota Statutes, Chapter 524, Uniform Probate Code. For recipients who die on or after August 1, 2003, estate is defined as the probate estate under Minnesota Statutes, Chapter 524, together with all of the person's interests established on or after August 1, 2003 or proceeds from those interests in real property owned by the person as a life tenant or joint tenant with a right of survivorship at the time of death, and to the extent the following interests become part of the probate estate, all interests or proceeds of those interests in securities, brokerage accounts or investment accounts owned by the person in beneficiary form and all interests in joint accounts, multiple party accounts and pay on death accounts or proceeds of those accounts. For recipients who die on or after July 1, 2009, estate includes assets conveyed to a survivor, heir, or assign of the recipient through survivorship, living trust, or other arrangements.

Minnesota also recovers from the estate of the deceased spouse of a predeceased Medicaid recipient according to Minnesota Statutes §256B.15. For Medicaid recipients who die on or after July 1, 2009, the estate of the Medicaid recipient is defined by state law to include legal title or interest in the undivided whole of all property owned by either spouse or the couple at the time of the recipient's death, property jointly owned or marital property at the time of the recipient's death, and any interests or proceeds of such interests that pass

through a joint tenancy, tenancy in common, survivorship, life estate, living trust or other arrangement. Recovery of a claim against the estate of a spouse who did not receive medical assistance ("nonrecipient spouse"), for medical assistance paid on behalf of his or her predeceased spouse, applies to the full value of all assets and interests in the estate of the nonrecipient spouse that were property of or can be traced to property held by the recipient spouse or the nonrecipient spouse or both during the marriage. Any assets, proceeds of assets and income from such assets, that were jointly owned property at any time during the marriage or marital property including all property in which either spouse had an interest at the time of marriage and property acquired by either or both during the marriage, regardless of how acquired, titled or owned, or whether transferred between spouses, are subject to recovery. Recovery in the estate of the nonrecipient spouse does not apply to assets attributable to a subsequent spouse when the nonrecipient spouse has remarried, or to assets acquired individually with non-marital assets or interests by the nonrecipient spouse after the death of the recipient spouse.

For an individual covered under a long-term care insurance partnership policy issued on or after July 1, 2006, estate does not include assets or resources disregarded for Medicaid eligibility under Attachment 2.6-A, Supplement 8b and any unused amount at death of assets that may be disregarded based on the total dollar amount of benefits utilized by the participant under the partnership policy.

The personal representative of the participant's estate has the burden of proving that assets in the estate of the participant or participant's surviving spouse were assets, portions of assets or proceeds from assets disregarded for Medicaid eligibility during the participant's lifetime.

If the value of assets disregarded during a participant's lifetime is less than the amount of benefits received under the participant's long-term care partnership policy, the personal representative of the participant may apply any unused amount of partnership asset protection to additional assets in the estate so that the total amount of disregarded assets is equal the amount of benefits received.

The personal representative has the burden of establishing the unused value of partnership asset protection. To determine a participant's unused amount of partnership asset protection at the time of estate recovery, reduce the total amount of the participant's partnership policy benefits utilized by the assets disregarded for Medicaid eligibility purposes during lifetime, valued as follows:

(i) The value on the date of the participant's death of assets, portions of asset or proceeds of assets retained or possessed by, accessible to or under the control of the participant or the participant's on the date of the participant's death;

(ii) The value on the date of transfer of assets, portions of assets or proceeds of assets transferred to a third party during the participant's lifetime by either the participant or the participant's spouse.

*individual's home – An individual's home, for the purpose of the Medical Assistance lien, is real property in which the recipient has an ownership interest, and which the recipient occupied as a primary dwelling immediately prior to admission to a medical institution.

**equity interest in the home* – Equity interest in the home means an ownership interest recognized under Minnesota law.

**residing in the home for at least one or two years on a continuous basis* – Residing in the home on a continuous basis means the person occupies the home as his or her primary dwelling, and intends to continue to occupy such home for the indefinite future.

**lawfully residing* – Lawfully residing means residing in a manner not contrary to, or forbidden by law.

** discharge from the medical institution and return home* – Discharge from a medical institution is actual discharge to the recipient's home, which is not a medical institution. Discharge does not include medical leave days or therapeutic leave days, or visitation to a home per plan of treatment.

4. The State defines undue hardship as follows:

The State follows the mandatory hardship standards for exemption of certain income, resource and property interests of American Indian and Alaska Natives specified in section 3810(A)(7) of the State Medicaid Manual.

The State does not otherwise define undue hardship in finite terms, but guides the determination process. These circumstances are not exclusive as there may be other situations that cause undue hardship. An undue hardship may exist when the circumstances described in one or more of the following paragraphs are present:

A. The estate claim could not be paid except by the sale of assets (real or personal property), subject to probate proceedings, for which the following statements are true for a period of at least 180 days prior to the date the decedent died and continue as true –

- the assets are used by the waiver applicant to produce income in his or her trade profession, or occupation, (trade, profession or occupation include a working farm that the waiver applicant actually operates, but does not include a farm that is not worked by the applicant, or a farm that is rented); and

- the assets are a necessary part of the waiver applicant's trade, profession or occupation; and

- the trade, profession or occupation in which the assets are used is the waiver applicant's sole source of income; and

- the waiver applicant has worked continuously and exclusively in the trade, profession or occupation in which the assets are used.

B. The estate claim could not be paid except by the sale of the decedent's real estate subject to probate proceedings and the following are true –

- the waiver applicant, with an ownership interest in the property, actually and continuously occupies the real estate as his or her only dwelling place for at least 180 days prior to the date the decedent died and continues to occupy the dwelling; or an adult grandchild of the decedent resided in the decedent medical assistance recipient's home for at least two years immediately before the grandparent's institutionalization and since the date of the grandparent's institutionalization, continues to lawfully reside in the dwelling following the grandparent's death, and establishes by a preponderance of the evidence having provided care to the grandparent who received medical assistance, that the care was provided before institutionalization, and that the care permitted the grandparent to reside at home rather than in an institution; and

- the real estate for which the hardship waiver is requested was classified as homestead property for property tax purposes under Minnesota Statutes, section 273.124 throughout the entire period of time referred to in the prior paragraph.

C. Notwithstanding anything else to the contrary, hardship does not exist if the decedent took any illegal actions to divest or divert assets in order to avoid estate recovery.

5. The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective:

A. The Department of Human Services delegates the authority to recover Medicaid claims to county human service agencies. Claimants may request a waiver for undue hardship from the county agency filing the claim. The written notice claimants receive of the county's decision includes information on the right to appeal the decision through the State's administrative fair hearing process under Minnesota Statutes section 256.045.

B. The county agency will not waive an estate claim~~,~~ even if circumstances are present that would grant a waiver for undue hardship, if the decedent's heirs or survivors would not receive a benefit from the waiver because of other filed claims against the estate.

C. The county agency will withdraw any estate claim, either fully or partially, after a determination of hardship has been made to all or part of the estate's assets. In the event that an estate claim has not been filed, the county agency will not file an estate claim in cases where a determination of hardship has been made on all or part of the estate assets.

D. An estate claim need not be filed in probate when it would not be cost-effective to make a recovery from the deceased medical assistance recipient's or recipient's spouse's estate. The decision to not file an estate claim can be made without an application being made for a waiver based on undue hardship.

6. The State defines cost-effective as follows (include methodology/thresholds used to determine cost-effectiveness):

Cost-effective for estate claim purposes means that the total amount of the claim that the State is legally entitled to file, or the total amount the State is legally entitled to collect after filing an estate claim is equal to or greater than the estimated costs for filing, pursuing, and collecting the estate claim. In determining that recovery from an estate is not cost-effective, the costs to pursue the recovery are considered, including attorney time, travel, court fees, fees for a personal representative, staff and technical support costs.

7. The State uses the following collection procedures (including specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):

The State follows these steps:

A. Reasonable effort to identify as many heirs and devisees as possible, including occupants with an ownership interest in the decedent's homestead.

B. Send to each of the identified individuals a Notice of Claim and an Application for a Waiver of Claim. This form contains

1. a statement of the claim
2. notice of the right to apply for a hardship waiver
3. a statement of what constitutes undue hardship
4. procedures and instructions for filing an application for an undue hardship, and the time period of 30 days to file an application from receipt of notice
5. information regarding appeal rights and procedures

C. Review and determination on each application for waiver

1. 30 day time period to make a determination on the application for waiver
2. written response of the determination
3. information regarding appeal rights and procedures

Medicaid Premiums and Cost Sharing

State Name: Minnesota

OMB Control Number: 0938-1148

Transmittal Number: MN - 15 - 0013

Expiration date: 10/31/2014

Cost Sharing Requirements G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. Yes

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

☐ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

☐ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

- ☒ The state includes an indicator in the Medicaid Management Information System (MMIS)
- ☒ The state includes an indicator in the Eligibility and Enrollment System
- ☒ The state includes an indicator in the Eligibility Verification System
- ☐ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider
- ☒ Other process

Description:

The Department issues bulletins and provider updates as cost-sharing requirements change. The Department also describes in its provider manual, all services and recipients subject to cost-sharing

☐ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. Yes

☑ The state ensures that before providing non-emergency services and imposing cost sharing for such services, that the hospitals providing care:

- [ ] Conduct an appropriate medical screening under 42 CFR 489.24, subpart G to determine that the individual does not need emergency services;
- [ ] Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;
- [ ] Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;
- [ ] Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and
- [ ] Provide a referral to coordinate scheduling for treatment by the alternative provider.

- [x] The state assures that it has a process in place to identify hospital emergency department services as non-emergency for purposes of imposing cost sharing. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

The process for identifying emergency department services as non-emergency for purposes of imposing cost sharing is:

Hospital emergency departments are informed that the copay applies to non-emergency services received, when the above conditions regarding screening, counseling and referral are met. An emergency is defined as a medical condition that manifests with acute symptoms (including severe pain) that, without immediate medical attention, could seriously jeopardize the physical or mental health of the individual or, with a pregnant woman, the health of the woman or unborn child. Hospitals have access to the Department's online provider directory in order to facilitate referrals.

Cost Sharing for Drugs

The state charges cost sharing for drugs. Yes

The state has established differential cost sharing for preferred and non-preferred drugs. Yes

- [ ] The state identifies which drugs are considered to be non-preferred.
- [x] The state assures that it has a timely process in place to limit cost sharing to the amount imposed for a preferred drug in the case of a non-preferred drug within a therapeutically equivalent or similar class of drugs, if the individual's prescribing provider determines that a preferred drug for treatment of the same condition either will be less effective for the individual, will have adverse effects for the individual, or both. In such cases, reimbursement to the pharmacy is based on the appropriate cost sharing amount.

Beneficiary and Public Notice Requirements

- [x] Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

PRA Disclosure Statement

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V.20140415

Effective Date: 7/1/2015 Approval Date: 12/23/15

Medicaid Premiums and Cost Sharing

State Name: Minnesota

OMB Control Number: 0938-1148

Transmittal Number: MN - 15 - 0013

Expiration date: 10/31/2014

Cost Sharing Amounts - Categorically Needy Individuals G2a

1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals. Yes

Services or Items with the Same Cost Sharing Amount for All Incomes

	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	
+	Non-preventive office visit	3.00	$	Visit	Charged per office visit that was not subject to the family deductible. No co-payment for an office visit for physical therapy, occupational therapy, speech therapy, or mental health services. Only one co-payment per day, per treating provider.	X
+	Non-emergency visit to a hospital-based emergency room	3.50	$	Visit	Charged per visit that was not subject to the family deductible. Only one co-payment per day, per treating provider.	X
+	Family deductible	2.85	$	Month	The deductible is applied to the first eligible service received each month. This amount shall be increased each year beginning January 1, 2016, by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year, and then rounded to the next higher five cent increment. No deductible applies to services in which a co-pay was assessed or the following: chemical dependency treatment services, pharmacy services, dental services, chiropractic services, eyeglasses, hearing aids and oxygen.	X
+	Prescribed drugs: Non -preferred drugs (brand-name)	3.00	$	Prescription	No co-payment for: 1) anti-psychotic drugs used for treatment of mental illness; or 2) contraceptives.	X
+	Prescription drugs: Preferred drugs (generic)	1.00	$	Prescription	No co-payment for: 1) anti-psychotic drugs used for treatment of mental illness; or 2) contraceptives.	X

Services or Items with Cost Sharing Amounts that Vary by Income

Service or Item:

Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+							X

Medicaid Premiums and Cost Sharing

Add Service or Item

Cost Sharing for Non-preferred Drugs Charged to Otherwise ~~Exempt~~ Individuals

If the state charges cost sharing for non-preferred drugs (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise ~~exempt~~ individuals.	No

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals.	No

PRA Disclosure Statement

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Medicaid Premiums and Cost Sharing

State Name: Minnesota

OMB Control Number: 0938-1148

Transmittal Number: MN - 15 - 0013

Expiration date: 10/31/2014

Cost Sharing Amounts - Medically Needy Individuals	G2b
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to all medically needy individuals.	Yes
The cost sharing charged to medically needy individuals is the same as that charged to categorically needy individuals.	Yes

PRA Disclosure Statement

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Medicaid Premiums and Cost Sharing

State Name: Minnesota

OMB Control Number: 0938-1148

Transmittal Number: MN - 15 - 0013

Expiration date: 10/31/2014

Cost Sharing Amounts - Targeting	G2c
1916 1916A 42 CFR 447.52 through 54	
The state targets cost sharing to a specific group or groups of individuals.	No

PRA Disclosure Statement

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Medicaid Premiums and Cost Sharing

State Name: Minnesota

OMB Control Number: 0938-1148

Transmittal Number: MN - 15 - 0013

Expiration date: 10/31/2014

Cost Sharing Limitations G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

☐ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).

☐ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:

- ☐ 133% FPL; and
- ☐ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.

☐ Disabled or blind individuals under age 18 eligible for the following eligibility groups:

- ☐ SSI Beneficiaries (42 CFR 435.120).
- ☐ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
- ☐ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).

☐ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.

☐ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).

☐ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.

☐ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.

☐ An individual receiving hospice care, as defined in section 1905(o) of the Act.

☐ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.

☐ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. Yes

Indicate below the age of the exemption:

- ( ) Under age 19
- ( ) Under age 20
- (•) Under age 21
- ( ) Other reasonable category

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. Yes

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- [■] Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- [■] Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- [■] Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- [■] Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- [■] Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- [■] To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - [☒] The state accepts self-attestation
  - [☐] The state runs periodic claims reviews
  - [☒] The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - [☒] The Eligibility and Enrollment and MMIS systems flag exempt recipients

☐ Other procedure

Additional description of procedures used is provided below (optional):

Through September 30, 2016, the Department exempts from cost sharing all American Indians. Beginning no later than October 1, 2016, the Department will exempt from cost sharing only those American Indians who are currently receiving, or have ever received, an item or service furnished by an Indian health care provider, or through referral under contract health services, in accordance with 42 CFR 447.56(a)(1)(x).

☐ To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

☒ The MMIS system flags recipients who are exempt

☒ The Eligibility and Enrollment System flags recipients who are exempt

☐ The Medicaid card indicates if beneficiary is exempt

☒ The Eligibility Verification System notifies providers when a beneficiary is exempt

☐ Other procedure

Additional description of procedures used is provided below (optional):

The Department's provider manual includes information describing services and individuals exempt from cost-sharing.

Payments to Providers

☑ The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. Yes

☑ The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

☑ Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

☐ The percentage of family income used for the aggregate limit is:

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- (•) 5%
- ( ) 4%
- ( ) 3%
- ( ) 2%
- ( ) 1%
- ( ) Other: [ ] %

[■] The state calculates family income for the purpose of the aggregate limit on the following basis:

- ( ) Quarterly
- (•) Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. [Yes]

[■] Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

- [ ] As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.
- [ ] Managed care organization(s) track each family's incurred cost sharing, as follows:
- [X] Other process:

As claims are submitted for dates of service within the family's current monthly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit using the state's MMIS system. Once the family reaches the aggregate limit, based on incurred cost sharing, no additional cost-sharing obligations are incurred until the next month. Providers receive information regarding the recipient's cost-sharing as they verify eligibility through the eligibility verification system. At initial enrollment, recipients receive information related to cost-sharing and may contact the member services help-desk with additional questions, including the status of their monthly cost-sharing limit.
Recipients with household income exceeding 100% FPL are not expected to be at risk of reaching the aggregate family limit. Through December 31, 2016, such recipients must manually track their cost sharing charges and contact the recipient help desk to request a refund of excess cost sharing payments. This process is fully described on the Department's website. Beginning no later than January 1, 2017, the Department will track cost sharing for these recipients and notify them once they reach their monthly cost sharing limit.

[■] Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

Once the family reaches the aggregate limit, based on incurred cost sharing, no additional cost-sharing obligations are incurred until the next month. Providers receive information regarding the recipient's cost-sharing as they verify eligibility through the eligibility verification system. At initial enrollment, recipients receive information related to cost-sharing and may contact the member services help-desk with additional questions, including the status of their

monthly cost-sharing limit. Beginning no later than January 1, 2017, the Department will also notify recipients via mail that they have reached their monthly cost sharing limit. Recipients will have the option to receive the notice electronically once that feature is operable.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. Yes

Describe the appeals process used:

All appeals follow the state's fair hearing process in accordance with 42 C.F.R. Part 431, Subpart E.

Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

Providers who charge cost-sharing in excess of the family's monthly limit must refund the overage to the recipient. If necessary, the MMIS system will re-process claims and reimburse the provider(s)the correct payment amount. The provider(s) then refunds to the recipient the amount of cost-sharing determined to exceed the aggregate limit for the month.

Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Reported changes in circumstance are applied through the state's eligibility system. Any changes that affect the recipient's aggregate cost-sharing limit are applied automatically.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). Yes

Description of additional aggregate limits:

The state limits cumulative prescription drug charges to $12 per person per month.

PRA Disclosure Statement

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Effective Date: 7/1/2015 Approval Date: 12/23/15

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge: Deductible	Coinsurance	Copay*	Amount and Basis for Determination
nonpreventive visit		X		$3 copay per office visit that was not subject to the family deductible. No copayment for an office visit for physical therapy, occupational therapy, speech therapy, or mental health services. Only one copayment per day, per treating provider. The average payment for a nonpreventive visit exceeds $50.01.
nonemergency visits to hospital based emergency room		X		$3.50 copay per visit that was not subject to the family deductible. Only one copayment per day, per treating provider. The average payment for hospital-based emergency room emergency room exceeds $50.01.
Monthly family deductible	X			Effective January 1, 2013, one $2.65 deductible is applied to the first eligible service received each month. This amount shall be increased each year beginning January 1, 2014, by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year, and then rounded to the next higher five cent increment. No deductible applies to the following: chemical dependency treatment services, pharmacy services, dental services, chiropractic services, eyeglasses, hearing aids and oxygen.

* In addition to the services and recipients not subject to a deductible or copayment in § 1916(a)(2), § 1916(j), and § 1916A(b) of the SSA, and in 42 C.F.R. § 447.53(b), the following are not subject to a deductible or copayments: services paid for by Medicare, for which the Department pays the Medicare coinsurance and deductible.

OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge: Deductible	Coinsurance	Copay*	Amount and Basis for Determination
• Prescribed drugs				
a. Brand-name			X	a. $3 per prescription. No copayment for: 1)anti-psychotic drugs used for treatment of mental illness; or 2) contraceptives. The average payment for brand-name prescriptions exceeds $50.01.
b. generic			X	b. $1 per prescription. No copayment for: 1)anti-psychotic drugs used for treatment of mental illness; or 2) contraceptives. The average payment for generic prescriptions is $10.01 to $25.00.

* In addition to the services and recipients not subject to a copayment in §1916(a)(2), and in 42 CFR §447.53(b), the following are not subject to copayments: 1) services that are 100% federally funded and are provided by an IHS or 638 facility; and 2) services paid for by Medicare, for which the Department pays the Medicare coinsurance and deductible.

OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

~~B. The method used to collect cost sharing charges for categorically needy individuals:~~

~~X Providers are responsible for collecting the cost sharing charges from individuals.~~

~~_ The agency reimburses providers the full Medicaid rate for a service and collects the cost sharing charges from individuals.~~

~~C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:~~

~~Providers cannot deny services to recipients unable to pay copayments.~~

~~The method for determining whether a recipient is unable to pay is the recipient's assertion that he or she is unable to pay the copayment. Any uncollected copayment amount is considered a debt to the provider.~~

OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

~~D. The procedures for implementing and enforcing the exclusions from cost-sharing contained in 42 CFR §447.53(b) are described below:~~

- ~~Department bulletins and provider updates~~
- ~~Department's "Minnesota Health Care Programs" provider manual~~
- ~~State Register notice published June 30, 2003~~
- ~~recipient notice~~
- ~~Department's Eligibility Verification system (automated telephone and on-line information service for providers)~~
- ~~Automated payment system that edits billings for services excluded from copayments. These services are paid at normal rates. If, after a copay is paid, the system receives corrected information regarding the excluded status of a recipient or regarding an excluded service, the system is capable of reprocessing the claim.~~

~~E. Cumulative maximums on charges:~~

~~X State policy does not provide for cumulative maximums.~~

~~Cumulative maximums have been established as described below:~~

- ~~$12 per month, per person, for prescription drug copayments~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

~~A. The following charges are imposed on the medically needy for services:~~

	~~Type of Charge~~			
~~Service~~	~~Deductible~~	~~Coinsurance~~	~~Copay*~~	~~Amount and Basis for Determination~~
~~nonpreventive visit~~		~~X~~		~~$3 copay per office visit that was not subject to the family deductible. No copayment for an office visit for physical therapy, occupational therapy, speech therapy, or mental health services. Only one copayment per day, per treating provider. The average payment for a nonpreventive visit exceeds $50.01.~~
~~nonemergency visits to hospital based emergency room~~		~~X~~		~~$3.50 copay per visit that was not subject to the family deductible. Only one copayment per day, per treating provider. The average payment for hospital-based emergency room emergency room exceeds $50.01.~~
~~Monthly family deductible~~	~~X~~			~~Effective January 1, 2013, one $2.65 deductible is applied to the first eligible service received each month. This amount shall be increased each year beginning January 1, 2014, by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year, and then rounded to the next higher five cent increment. No deductible applies to the following: chemical dependency treatment services, pharmacy services, dental services, chiropractic services, eyeglasses, hearing aids and oxygen.~~

~~* In addition to the services and recipients not subject to a deductible or copayment in § 1916(a)(2), 1916(j), § 1916A(b)of the SSA and in 42 C.F.R. §447.53(b), the following are not subject to a deductible or copayments: services paid for by Medicare, for which the Department pays the Medicare coinsurance and deductible.~~

OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

~~A. The following charges are imposed on the medically needy for services:~~

~~Service~~	~~Type of Charge~~ ~~Deductible~~	~~Coinsurance~~	~~Copay*~~	~~Amount and Basis for Determination~~
~~• Prescribed drugs~~				
~~a. Brand-name~~		~~X~~		~~a. $3 per prescription. No copayment for: 1)anti-psychotic drugs used for treatment of mental illness; or 2) contraceptives. The average payment for brand-name prescriptions exceeds $50.01.~~
~~b. generic~~		~~X~~		~~b. $1 per prescription. No copayment for: 1)anti-psychotic drugs used for treatment of mental illness; or 2) contraceptives. The average payment for generic prescriptions is $10.01 to $25.00.~~

~~* In addition to the services and recipients not subject to a copayment in §1916(b)(2), and in 42 CFR §447.53(b), the following are not subject to copayments: 1) services that are 100% federally funded and are provided by an IHS or 638 facility; and 2) services paid for by Medicare, for which the Department pays the Medicare coinsurance and deductible.~~

OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

~~B. The method used to collect cost sharing charges for categorically needy individuals:~~

~~X Providers are responsible for collecting the cost sharing charges from individuals.~~

~~_ The agency reimburses providers the full Medicaid rate for a service and collects the cost sharing charges from individuals.~~

~~C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:~~

~~Providers cannot deny services to recipients unable to pay copayments.~~

~~The method for determining whether a recipient is unable to pay is the recipient's assertion that he or she is unable to pay the copayment. Any uncollected copayment amount is considered a debt to the provider.~~

OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

~~D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR §447.53(b) are described below:~~

- ~~Department bulletins and provider updates~~
- ~~Department's "Minnesota Health Care Programs" provider manual~~
- ~~State Register notice published June 30, 2003~~
- ~~recipient notice~~
- ~~Department's Eligibility Verification system (automated telephone and on-line information service for providers)~~
- ~~If, after a copay is paid, the system receives corrected information regarding the excluded status of a recipient or regarding an excluded service, the system is capable of reprocessing the claim.~~

~~E. Cumulative maximums on charges:~~

~~__ State policy does not provide for cumulative maximums.~~

~~X Cumulative maximums have been established as described below:~~

- ~~$12 per month, per person, for prescription drug copayments~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: MINNESOTA

Premiums Imposed on Low Income Pregnant Women and Infants

~~A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(i)(IX)(A) and (B) of the Act:~~

~~No premium is imposed.~~

~~B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):~~

~~Not applicable.~~

Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: MINNESOTA

~~C. State or local funds under other programs are used to pay for premiums:~~

~~☐ Yes ☐ No~~

~~Not Applicable.~~

~~D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:~~

~~Not Applicable.~~

Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: MINNESOTA

Optional Sliding Scale Premiums Imposed on
Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

No premium is imposed.

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

Not Applicable.

~~D~~escription provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: MINNESOTA

C. State or local funds under other programs are used to pay for premiums:

[ ] Yes [ ] No

Not Applicable.

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

Not Applicable.

scription provided on attachment.

Methods and Standards for Determining Payment Rates for Inpatient Hospital Services Provided by Non-State Owned Facilities

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SECTION 1.0 PURPOSE AND SCOPE

The Minnesota inpatient hospital payment system for the Medical Assistance Program is authorized by state statute. Payment rates for rehabilitation and most other large hospitals are based on the 3M All Patient Refined Diagnosis Related Grouper (APR-DRG) to reflect a per discharge payment schedule. Additional rate methodologies are established for critical access hospitals (CAH) and long-term hospitals.

Rates for the other payment methodologies are based on the cost finding principles of the Medicare program in the base period. The rates are established for each rate period year using hospital specific Medical Assistance claims and cost data.

To be eligible for payment, inpatient hospital services must be medically necessary, and if required, have the necessary prior approval from the Department.

Minnesota has in place a process for public comment that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

SECTION 2.0 DEFINITIONS

Accommodation service. "Accommodation service" means those inpatient hospital services included by a hospital in a daily room charge. They are composed of general routine services and special care units. These routine and special care units include the nursery, coronary, intensive, neonatal, rehabilitation, psychiatric, and chemical dependency units.

Adjusted base year operating cost. "Adjusted base year operating cost" means a hospital's allowable base year operating cost adjusted by the hospital cost index.

Admission. "Admission" means the time of birth at a hospital or the act that allows a recipient to officially enter a hospital to receive inpatient hospital services under the supervision of a physician who is a member of the medical staff.

Allowable base year operating cost. "Allowable base year operating cost" means a hospital's base year inpatient hospital cost per discharge, admission or per day that is adjusted for case mix.

Ancillary service. "Ancillary service" means inpatient hospital services that include laboratory and blood, radiology, anesthesiology, electrocardiology, electroencephalography, pharmacy and intravenous therapy, delivery and labor room, operating and recovery room, emergency room and outpatient clinic, observation beds, respiratory therapy, physical therapy, occupational therapy, speech therapy, medical supplies, renal dialysis, and psychiatric and chemical dependency services customarily charged in addition to an accommodation service charge.

Base year. "Base year" means a hospital's fiscal year or years that is recognized by Medicare, or a hospital's fiscal year specified by the Commissioner if a hospital is not required to file information with Medicare from which cost and statistical data are used to establish rates.

Charges. "Charges" means the usual and customary payment requested by the hospital of the general public.

Cost outlier. "Cost outlier" means a claim with significantly higher costs.

Cost-to-charge ratio (CCR). "Cost-to-charge ratio" means a ratio of a hospital's allowable inpatient hospital costs to its allowable charges for inpatient hospital services, from the appropriate Medicare cost report.

Critical Access Hospital. "Critical access hospital" means inpatient hospital services that are provided by a hospital designated by Medicare as a critical access hospital.

Diagnostic categories. "Diagnostic categories" means the assignment of all patient-refined

diagnosis-related groups (APR-DRGs). The DRG classifications must be assigned according to the base year discharges for inpatient hospital services under the APR-DRG, rehabilitation, and long term hospital methodologies.

Discharge. "Discharge" means the act that allows a recipient to officially leave a hospital.

Disproportionate Population Adjustment Factor. "Disproportionate Population Adjustment (DPA) factor" is the numerical multiplier applied to each eligible claim to add the Disproportionate Share Hospital payment to the payment amount computing using the applicable rate methodology.

Fixed-loss amount. "Fixed-loss amount" means the amount added to the base DRG payment to establish the outlier threshold amount. For rates set using 2012, 2014, 2016, or 2018 or as the base year, the fixed loss amount is $70,000 dollars. For rates set using 2019 s the base year, the fixed loss amount is $75,500.

Frontier State. "Frontier state" means a state where at least 50 percent of the counties have a population density of less than six people per square mile.

Frontier State Adjustment. The frontier state adjustment is a provision of the Affordable Care Act that requires CMS to adopt a hospital wage index that is not less than 1.0 for hospitals located in frontier states.

Healthcare Cost and Utilization Project (HCUP). "HCUP" is a family of health care databases and related tools for research and decision making. HCUP is sponsored by the Agency for Healthcare Research and Quality. It is the largest collection of longitudinal hospital care data in the United States, with all-payer, encounter-level information beginning in 1988.

Hospital-acquired condition. "Hospital-acquired condition" means a condition represented by an ICD-9-CM or ICD-10-CM diagnosis code, that is listed on the Centers for Medicare and Medicaid Services annual hospital-acquired conditions list that is not identified by the hospital as present on admission and is designated as a complicating condition or major complicating condition.

Hospital outlier index. "Hospital outlier index" means a hospital adjustment factor used to calculate outlier payments to prevent the artificial increase in cost outlier payments from the base year to the rate year resulting from charge or cost increases above the Medicare estimated projected increases.

Inpatient hospital costs. "Inpatient hospital costs" means a hospital's base year inpatient hospital service costs determined allowable under the cost finding methods of Medicare including direct and indirect medical education costs.

Inpatient hospital service. "Inpatient hospital service" means a service provided by or under the supervision of a physician after a recipient's admission to a hospital and furnished in the hospital. This includes outpatient services provided by the same hospital that directly precede the admission.

Labor-related share. "Labor-related share" means an adjustment to the payment rate by a factor that reflects the relative differences in labor costs among geographic areas.

Local trade area hospital. "Local trade area hospital" means a hospital that is located in a state other than Minnesota, but in a county that is contiguous to the Minnesota boarder.

Long-term hospital. "Long-term hospital" means a Minnesota hospital or a local trade area hospital that meets the requirements under Code of Federal Regulations, title 42, part 412, section 23(e).

Marginal cost factor. "Marginal cost factor" means a percentage of the estimated costs recognized above the outlier threshold amount. For rates set using 2019 as the base year, the marginal cost factor is 50 percent for DRGs with a severity of illness factor of 1, 2, 3 or 4.

Medical Education Payment Adjustment. "Medical Education Payment Adjustment" means the percentage multiplier needed to increase payments by the amount of the Medical Education Research Costs distribution for the hospital or system of hospitals and clinics as determined under MN Statutes 62J.692, subdivision 4.

Metropolitan statistical area hospital or MSA hospital. "Metropolitan statistical area hospital" or "MSA hospital" means a hospital located in a metropolitan statistical area as determined by Medicare for the October 1 prior to the most current rebased rate year.

MinnesotaCare Tax Add-on Amount. "MinnesotaCare Tax Add-on Amount" is equal to the percentage value set in Minnesota Statutes section 259.52 for the time period that covers the discharge date of the claim.

Non-metropolitan statistical area hospital or non-MSA hospital. "Non-metropolitan statistical area hospital" or "non-MSA hospital" means a hospital that is not located in a Metropolitan statistical area as determined by Medicare for the October 1 prior to the most current rebased rate year.

Operating costs. "Operating costs" means all allowable operating costs.

Outlier threshold amount. "Outlier threshold amount" is equal to the sum of the hospital's standard payment rate and the fixed-loss amount.

Out-of-area hospital. "Out-of-area hospital" means a hospital that is located in a state other than Minnesota, and is not a local trade area hospital.

Policy Adjuster. "Policy adjuster" means an adjustment made to a specific range or subset of APR-DRGs based on category of service, age, or hospital type to allow for a payment adjustment to the specific APR-DRG claims.

Property Costs. "Property Costs" means inpatient hospital costs not subject to the hospital cost index, including depreciation, interest, rents and leases, property taxes and property insurance.

Policy Adjustment Factor. "Policy adjustment factor" means the base value of the specific policy adjuster as adopted by the Department.

Provider-Preventable Condition. "Provider–Preventable Condition" means a condition identified by the state for non-payment under Section 5.a. of Attachment 4.19-B which includes:

- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient.

In compliance with 42 CFR 447.26(c), the State provides:

1. That no reduction in payment for a Provider Preventable Condition (PPC) will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
2. That reductions in provider payment may be limited to the extent that the following apply:
   a. The identified PPC would otherwise result in an increase in payment.
   b. The state can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the PPC.
   c. Assurance that non-payment for PPCs does not prevent access to services for Medicaid beneficiaries.

Rate year. "Rate year" means a state fiscal year from July 1 through June 30 in which the discharge occurred.

Rehabilitation Hospital. "Rehabilitation hospital" means inpatient hospital services that are provided by a hospital or unit designated by Medicare as a rehabilitation hospital or rehabilitation distinct part. The term rehabilitation hospital encompasses rehabilitation hospitals and rehabilitation distinct parts.

Relative value. "Relative values" are weighted adjustments applied to the APR-DRG to reflect the resources required to provide a given service. The relative values of APR-DRG hospitals and rehabilitation hospitals are based on APR-DRG "hospital specific relative value (HSRV)" national weights, developed by 3M based on Healthcare Cost and Utilization Project (HCUP)

National Inpatient Sample (NIS) discharge data.

Seven-county metropolitan area. "Seven-county metropolitan area" includes the following counties: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington.

Severity of Illness. "Severity of illness" (SOI) means the extent of physiologic decompensation or organ system loss of function the extent of which is noted by the four distinct subclasses: 1 - Mild; 2 – Moderate; 3 – Major; 4 – Extreme. The higher SOI subclasses reflect higher utilization of hospital resources and are generally expected to incur greater costs.

Transfer. "Transfer" means the movement of a recipient after admission from one hospital directly to another hospital with a different provider number or to or from a rehabilitation hospital.

Transitional Period. "Transitional period" applies to the initial period of time for APR-DRG Hospitals in Minnesota or local trade areas for discharges occurring on or after November 1, 2014 until the next re-basing.

Upper Payment Limit Demonstration Year. "Upper payment limit demonstration year" means the four consecutive quarters for which the upper payment limit demonstration was calculated.

Wage Index. "Wage index" means an adjustment to compensate for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. For areas with frontier state status the "Pre-floor Wage Index" is used.

SECTION 3.0 MEDICAL ASSISTANCE COST REPORTS

All Minnesota and local trade area hospitals receiving a disproportionate population adjustment payment, and all hospitals classified as a Critical Access Hospital must annually submit a Medical Assistance cost report within six months of the end of the hospital's fiscal year. The Department shall suspend payments to any hospital that fails to submit the required cost report. Payments will remain suspended until the report is filed with, and accepted by, the Department.

SECTION 4.0 ALL PATIENT-REFINED DIAGNOSIS-RELATED GROUP (APR-DRG) HOSPITALS

4.01 Establishment of base years.
Effective for discharges occurring on or after November 1, 2014, payment rates for services provided by hospitals located in Minnesota or the local trade area shall be paid using a base year of calendar year 2012. Effective for discharges occurring on or after July 1, 2017 payment rates for services provided by hospitals located in Minnesota or the local trade area shall be paid using a base year of calendar year 2014. Effective for discharges occurring on or after July 1, 2019 payment rates for services provided by hospitals located in Minnesota or the local trade area shall be paid using a base year of calendar year 2016. Effective for discharges occurring on or after January 1, 2022 payment rates for services provided by hospitals located in Minnesota or the local trade area shall be paid using a base year of 2018. Effective for discharges on or after July 1, 2023, payment rates for services provided by hospitals located in Minnesota or the local trade area shall be paid using a base year of 2019.

The rebasing in 2014 will be budget neutral, to ensure that the total aggregate payments under the rebased system are equal to the total aggregate payments made for the same number and types of services in the base year. Existing applicable rate increases or decreases applied to the hospitals being rebased during the entire base period will be incorporated into the budget neutrality calculation.

Effective for discharges occurring on or after July 1, 2017, and every two years thereafter, payment rates shall be rebased to reflect only those changes in hospital costs between the existing base year and the next base year. Changes in costs between base years shall be measured using the lower of the hospital cost index, or the percentage change in the case mix adjusted cost per claim. The base year for each rebasing period is established by considering the most recent year for which filed Medicare cost reports are available.

4.02 Determination of relative values. The APR-DRG relative values of the diagnostic categories will be based on the "HSRV" national weights developed by 3M utilizing the HCUP NIS discharge data applicable to the base year.

4.03 Statewide Standardized APR-DRG amount. The statewide, standardized amount is set such that aggregate, simulated new APR-DRG system-payments are equal to aggregate DRG model-claim, allowed amounts under the DRG system in effect in each base year plus the applicable inflation factor. For rates effective July 1, 2017, the model claims data will be CY 2014. For rates effective July 1, 2019, the model claims data will be CY 2016. For rates effective January 1, 2022, the model claims data will be CY 2017 and CY 2018. For rates effective July 1, 2023, the model claims data will be CY 2018 and CY 2019. The wage index and labor portions are based on factors in the FFY 2019 Medicare Inpatient Prospective Payment

System (IPPS). The wage indices include provider-specific reclassifications in the FFY 2016 Medicare IPPS, but do not include the frontier state adjustment in their FFY 2019~~8~~ Medicare IPPS wage index.

4.04 Wage-adjusted Base Rate. APR-DRG wage-adjusted base rates are calculated using a statewide standardized amount with the labor percentage adjusted by the applicable Medicare IPPS wage index for the rate year. MSA hospitals use the standard wage index.
Non-MSA hospitals use the rural wage index, but the Frontier State adjustment is not applied.

Wage-adjusted Base Rate =	(Statewide standardized APR-DRG amount multiplied by the labor percentage, multiplied by the applicable wage index) plus the (Statewide standardized APR-DRG amount multiplied by (1.0 minus the labor percentage))

A. Labor portion:

(1) Determine the Statewide standardized APR-DRG amount for the discharge
(2) Multiply by the product of the labor percentage and the applicable wage index

B. Non-labor portion:

(1) Determine the Statewide standardized APR-DRG amount for the discharge
(2) Multiply by the difference between one and the labor percentage

C. Sum the results of A and B.

SECTION 4.1 POLICY ADJUSTMENT FACTOR

Policy Adjustment factors are category-specific adjustments made to the payment. They are defined in terms of APR-DRG Base Groupings and include all SOI Categories. Policy Adjustment factors have a base value of 1.0 unless an adjustment factor has been adopted and indicated below by the Department.

Effective for the discharges on or after November 1, 2014, policy adjustments are applied to the following APR-DRG categories:

A. Mental Health: 740, 750, 751,752, 753, 754, 755, 756, 757, 758, 759,760

- A policy adjustment factor of 1.97 will be applied when the SOI is equal to one.
- A policy adjustment factor of 2.06 will be applied with the SOI is equal to two.
- A policy adjustment factor of 2.06 will be applied when the SOI is equal to three.

- A policy adjustment factor of 1.78 will be applied when the SOI is equal to four.

B. Neonate: 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 630, 631, 633, 634, 636, 639, 863
   - A policy adjustment factor of 1.00 will be applied to neonatal stays.

C. Normal New Born: 626, 640
   - A policy adjustment factor of ~~1.28~~ 1.30 will be applied to deliveries without medical complications.

D. Obstetrics – Vaginal Deliveries: 560
   - A policy adjustment factor of ~~1.21~~ 1.20 will be applied to vaginal deliveries in a hospital located outside the seven-county metro area.
   - A policy adjustment factor of 1.00 will be applied to vaginal deliveries in a hospital located within the seven-county metro area.

E. Obstetrics Cesarean: 540
   - A policy adjustment factor of 1.00 will be applied to cesarean deliveries.

F. Obstetrics Other: 541, 542, 543, 547, 548, 561, 564, 566
   - A policy adjustment factor of 1.00 will be applied for obstetrics services, other than child birth.

G. Transplant: 001, 002, 006, 007, 008, 011, 440
   - A policy adjustment factor of ~~1.41~~ 1.20 will be applied to transplant services.

H. Rehabilitation: 860
   - A policy adjustment factor of 1.00 will be applied to rehabilitation services.

I. Other Pediatric: all other APR-DRGs not listed in paragraphs A through H with patient age < 18 years old, and provided in a Children's hospital
   - A policy adjustment factor of 1.00 will be applied regardless of SOI.

J. Other Pediatric all other APR-DRGs not listed in paragraphs A through H with patient age < 18 years old, and not provided in a Children's hospital
   - A policy adjustment factor of 1.00 will be applied regardless of SOI.

K. Other Adult all other Base Groups with Age >18 years old

SECTION 4.2 TRANSITION ADJUSTMENT FACTOR

The transition adjustment factor is a provider-specific prospective value applied during the transitional period to ensure that a provider's aggregate simulated payments under rebased rates using base period claims data do not increase or decrease by more than five percent from aggregate base period payments.

SECTION 4.3 CALCULATION OF PAYMENT RATES

4.31 Standard Payment for Minnesota Hospitals

Standard Payment =	Wage-adjusted base rate, multiplied by the APR-DRG relative value, multiplied by the DPA factor, multiplied by the policy adjustment factor

A. Calculate wage-adjusted base rate
B. Multiply by the APR-DRG relative value
C. Multiply by the policy adjustment factor
D. Multiply by Disproportionate Population Adjustment factor

4.32 Standard Payment for Local Trade Area Hospitals

Standard Payment =	Wage-adjusted base rate, multiplied by the APR-DRG relative value, multiplied by the policy adjustment factor

A. Calculate wage-adjusted base rate
B. Multiply by the APR-DRG relative value
C. Multiply by the policy adjustment factor

4.33 Transfer Payment for Minnesota, Local Trade Area, and Out-of-area Hospitals

Transfer Payment =	(Standard payment, divided by the average length of stay for the APR-DRG discharge), multiplied by the (actual length of stay plus 1.0)

A. Divide the standard payment by the average length of stay for the APR-DRG
B. Multiply by the sum of the actual length of stay plus 1.0

The value calculated in B cannot exceed the average length of stay for the APR-DRG. Average lengths of stay for APR-DRG discharges are listed in the HCUP data file. A hospital may not receive a transfer payment that exceeds the hospital's applicable standard payment rate unless that discharge is an outlier.

A discharge that immediately precedes an admission paid pursuant to Section 4.57 governing contracts for psychiatric services is ineligible for a transfer payment.

4.34 Outlier Payment for Minnesota Hospitals

Outlier Payment =	The applicable marginal cost factor multiplied by the DPA factor, multiplied by the difference between (allowable charges, multiplied by the hospital's overall cost to charge ratio) and the [(wage-adjusted base rate, multiplied by the relative value, multiplied by the policy adjustment factor) plus the fixed loss amount]

A. Calculate cost

(1) Multiply allowable charges by the hospital's ~~base year~~ cost to charge ratio

B. Calculate facility outlier threshold amount

(1) Multiply the wage-adjusted base rate by the relative value
(2) Multiply the result in item (1) by the policy adjustment factor
(3) Add the fixed loss amount to the result in item (2)

C. Subtract B from A.

D. If the result in C is positive, multiply the difference by the applicable marginal cost factor and the DPA factor to determine the outlier payment. If result in C is negative, the outlier payment is zero.

4.35 Outlier Payment for Local Trade Area and Out-of-Area Hospitals

Outlier Payment =	The applicable marginal cost factor multiplied by the difference between (allowable charges, multiplied by the hospital's overall cost to charge ratio) and the [(wage-adjusted base rate, multiplied by the relative value, multiplied by the policy adjustment factor) plus the fixed loss amount]

A. Calculate cost

(2) Multiply allowable charges by the hospital's ~~base year~~ cost to charge ratio

B. Calculate the facility outlier threshold amount

(4) Multiply the wage-adjusted base rate by the relative value

(5) Multiply the result in item (1) by the policy adjustment factor
(6) Add the fixed loss amount to the result in item (2)

C. Subtract B from A.

D. If the result in C is positive, multiply the difference by the marginal cost factor to determine the outlier payment. If the result in C is negative, the outlier payment is zero.

4.36 Out-of-area Hospitals

Out-of-area Payment =	Statewide average wage-adjusted base rate, multiplied by the relative value, multiplied by the policy adjustment factor

A. Determine the average statewide wage-adjusted base rate for the APR-DRG discharge
B. Multiply by the relative value
C. Multiply by the policy adjustment factor

Payments to out-of-area hospitals may be established based on a negotiated rate if the Department contracts directly with the hospital.

4.37 Interim Payment Methodology
The Department shall pay an interim payment based on the methodologies existing prior to the rebasing effective July 1, 2023.

Upon implementation of the methodology described in this attachment, the Department shall reprocess all claims paid under an interim payment methodology.

4.38 Alternative Payment Methodology for Children's Hospitals
Effective for audit years following July 1, 2017, for each audit year in which the audit of the Disproportionate Share Hospital (DSH) payment requires the inclusion of days, costs, and revenues associated with patients who have private health care coverage and who are eligible for Medicaid, an alternative payment rate shall be calculated for Minnesota hospitals that are designated as Children's hospitals and enumerated as such by Medicare.

Alternative Payment =	Allowable Charges multiplied by the product of: The applicable base year cost-to-charge ratio and The cost coverage percentage for the applicable base year minus two percentage points.

A. Calculate Base Year Cost Coverage Percentage for each eligible hospital

(1) Multiply Base Year allowable charges by the hospital's Base Year cost-to-charge ratio to determine base year costs.
(2) Divide total Base Year Payments by total Base Year Costs as determined in (1).

B. Reduce Base Year Payment to Cost Ratio
(1) Subtract two percentage points from the result of (A).

C. Determine Payment Year Costs
(1) Multiply Payment Year Allowable Charges by the Base Year cost-to-charge ratio for each eligible hospital.

D. Determine Final Payment Amount
(1) Multiply the result of (C) by the result of (B).

Allowable base year costs are limited to Medicare allowable costs for providing inpatient hospital services to patients enrolled in Minnesota Medicaid on a fee-for-service basis. Base year costs shall be determined using the most recent Medicare Cost Report available on the date that is two years after the beginning of the calendar year that is the base year. Costs shall be determined using standard Medicare cost finding and cost allocation methods.

In any year in which a Children's hospital is paid using this alternative payment methodology, no payments under Section 8 shall be made to the hospital.

SECTION 4.39 Alternative Payment Methodology for Hospitals Receiving Directed Payments from Managed Care Plans

Effective for discharges on or after January 1, 2022, hospitals that are in the pool of providers receiving directed payments as required by contracts between the state and managed care plans will be paid using an alternative payment methodology. The alternative payment methodology will follow the provisions of sections 4.31 Standard payment, 4.33 Transfer payment, 4.34 Outlier payment, 4.37 Interim payment, 4.41 Rate adjustment and all of the provisions in section 4.5. The alternative payment methodology also includes the provisions in section 4.6 when the provider meets the requirements for payments under that section.

In addition to the payments under these provisions, a rate factor will be applied following the computation of the standard, transfer and outlier payments and prior to the application of the rate adjustment in section 4.41. For discharges on or after January 1, 2022, the alternative payment rate factor will be a factor equal to 99 percent of the sum of the factors as computed under sections 8.02, 8.03, and 8.04.

For providers paid under this alternative payment methodology, no payments under Section 8 shall be made.

SECTION 4.4 ~~Reserved~~ Alternate Payment Methodology for Hospitals with Extremely Long Lengths of Stay

Effective for the Disproportionate Share Hospital audit for calendar year 2021, a hospital that discharged a patient following a length of stay of more than twenty years shall receive total payments equal to 99 percent of the combined amount of the fee-for-service payments and the disproportionate share hospital payments for the year in which the patient was discharged.

For providers paid under this alternative payment methodology, no payments under Section 8 shall be made.

SECTION 4.41 RATE ADJUSTMENT
For hospitals located in Minnesota, the total payment, after third-party liability and spend down is increased by the MinnesotaCare tax add-on amount.

SECTION 4.5 OTHER PAYMENT FACTORS

4.51 Charge limitation. Individual hospital payments, including DPA payments, established for Medical Assistance covered inpatient services in addition to third party liability for discharges occurring in a rate year will not exceed the billed charges on each claim.

4.52 Reserved

4.53 Neonatal respiratory distress syndrome. For discharges to be paid under inpatient hospital rates that include the diagnosis of neonatal respiratory distress syndrome, services must be provided in a level II or above inpatient hospital nursery. Otherwise, payment will be determined by taking into account respiratory distress but not respiratory distress syndrome.

4.54 Non-payment for hospital-acquired and provider-preventable conditions. No payment will be made for the care, additional treatment or procedures, readmission to the hospital after discharge, increased length of stay, change to a higher diagnostic category, or transfer to another hospital when the charges are attributable to a hospital-acquired or provider-preventable condition. In the event of a transfer to another hospital, the hospital where the hospital-acquired or provider-preventable condition was acquired is responsible for any cost incurred at the hospital to which the patient with the condition is transferred.

4.55 Indian Health Service. Medical assistance payments to facilities of the Indian Health Service and facilities operated by a tribe or tribal organization under funding authorized by title I of the Indian Self-Determination and Education Assistance Act, Public Law Number 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, Public Law 106-260, or by United States Code, title 25, chapter 14, subchapter II, sections 450f to 450n, are excluded from the DRG system and are paid according to the rate published by the United States

assistant secretary for health under authority of United States Code, title 42, sections 248A and 248B.

4.56 Newborn Screening Fee. Effective for admissions occurring on or after July 1, 2023, payment rates shall be adjusted to include the increase to the fee that is effective on July 1, 2022, for newborn screening tests required the Minnesota Department of Health that is paid by the hospital for Medical Assistance recipients. This payment increase

shall be in effect until the increase is fully recognized within the base year cost.

4.57 Psychiatric services contracts. The Commissioner has determined that there is a need for access to additional inpatient hospital psychiatric beds for persons with either serious emotional disturbance or serious and persistent mental illness, who have been civilly committed or voluntarily hospitalized, and can be treated and discharged within 45 days (or, effective August 1, 2005, additional days beyond 45 based on the Department's individual review of medical necessity). In response, contracts with non-state operated hospitals to provide inpatient hospital psychiatric services to patients who will be dually committed to the non-state operated hospital and the State-operated regional treatment center, or who have agreed to hospitalization, have been established. Payment rates for these inpatient psychiatric services are negotiated and established in the contracts executed under an open bidding process between the Commissioner and the hospitals.

A. Parameters related to the acceptance of a proposal other than cost include:

(1) the quality of the utilization review plan;

(2) experience with mental health diagnoses; and

(3) the commitment process.

B. Parameters related to acceptance of a proposal on a financial and cost basis include:

(1) payer of last resort/payment in full compliance assurances;

(2) general experience operating within the Medicare/Medical Assistance programs; and

(3) financial integrity.

C. Voluntary hospitalizations are included in the contracts: If the attending physician indicates that the patient is in need of continued mental health inpatient treatment and that the patient is competent to consent to treatment (or has a substitute decision maker with the authority to consent to treatment).

Rates are established through the bid process with negotiation based on the cost of operating the hospital's mental health unit as derived from the Medicare cost report. The cost information, for comparison to a state-operated hospital, is adjusted to take into account average acuity and length of stay differences.

4.58 Medical Education and Research Costs.

4.58.1 MERC Payment Adjustment.

4.58.2 In addition to Medical Assistance payments

included in this Attachment, Medical Assistance provides for an additional annual payment according to the formula in Supplement 3 of this attachment. Effective for discharges on or after January 1, 2024, payments to each hospital and the affiliated clinics will be included in the payment rates for inpatient hospital services. Hospital systems may elect to have all MERC payments for each hospital and clinic within the system paid to a single hospital within the system. Payments made within the inpatient hospital rates shall be reconciled annually to ensure that total payments do not exceed the amounts determined in the formula in Supplement 3 of this attachment.

4.59 Reserved

4.60 Additional adjustment for Certain Hospitals

Hennepin County Medical Center and Regions Hospital. Effective July 15, 2001, in recognition of the services provided by the two largest safety net hospitals, an additional adjustment, in total for Hennepin County Medical Center and for Regions Hospital, will be made each year, after the close of the federal fiscal year, that is the difference between the non-State government-owned or operated hospital Medicare upper payment limit, as specified in Code of Federal Regulations, title 42, section 447.272, using Medicare payment methods for hospitals, and the non-State government-owned or operated hospital payments of this Attachment.

Effective for the payment attributable to the upper payment limit demonstration year 2010, and thereafter, out of the total available funding, payments to each of the two hospitals will be determined by:

A. Calculating an upper payment limit for each of the hospitals receiving payment under this section using the same methodology applied to the entire group of non-State government-owned hospitals.

B. Calculating a ratio for each of the hospitals receiving a payment under this section that is equal to:

(1) the difference between the upper payment limit for each hospital computed in A and total Medicaid payments to that hospital and, if positive,

(2) divided by the sum of the positive amounts of the differences between the upper payment limit and the Medicaid payments to each of the hospitals.

C. Applying the ratio computed in B to the difference between the upper payment limit for the non-State government-owned group of hospitals and total Medicaid payments to that group of hospitals.

The Department will make an interim payment. The Department will then reconcile the interim payment for each payment year after calculating the total value of the payment adjustment for each payment year.

SECTION 5.0 RESERVED

SECTION 6.0 CRITICAL ACCESS HOSPITALS (CAH)

6.01 Establishment of base years.

Effective for discharges occurring on or after July 1, 2015, payment rates for services provided by critical access hospitals located in Minnesota or the local trade area shall be paid using a base year of calendar year 2012. The base year will be updated (re-based) every two years to the most recent year for which filed, Medicare cost reports are available. The re-basing shall reflect changes in hospital costs between the existing base year and the next base year.

For every year that is not a re-basing year, payment rates shall be inflated using the Centers for Medicare & Medicaid Services' Inpatient Hospital Market Basket Index.

SECTION 6.2 CALCULATION OF PAYMENT RATES

6.21 Standard Payment for Minnesota and Local Trade Area Hospitals

Effective for discharges on or after July 1, 2015, payment rates shall be facility-specific, per diem payment rates. The per diem rates shall be based on a facility-specific percentage of costs as recorded on the most recently filed Medicare Cost Report as of March, 2014 for the cost report period ending in 2012. Effective for discharges on or after July 1, 2017, the per diem rates shall be based on a facility specific percentage of costs as recorded on the most recently filed Medicare Cost Report as of March 2016 for the cost report period ended in 2014. Effective for discharges on or after July 1, 2019, the per diem rates shall be based on a facility specific percentage of costs as recorded on the most recently filed Medicare Cost Report as of March 2018 for the cost report period ended in 2016. Effective for discharges on or after January 1, 2022, the per diem rates shall be based on facility specific percentage of costs as recorded on the most recently filed Medicare Cost Report as of January of 2020 for the cost report period ended in 2018. The calculated cost based rate shall be the final rate and will not be settled to actual, incurred costs.

Standard Payment =	Covered Days multiplied by facility-specific per diem rate.

A. Calculate a payment-to-cost ratio using allowable cost and revenue data from Medicare Cost Report

B. Determine payment-to-cost ratio tier

(1) Hospitals with base year payment-to-cost ratios at or below 80 percent shall have a per diem payment rate set to reimburse 85 percent of base year costs.
(2) Hospitals with base year payment to cost ratios above 80 percent up to and including 90

percent shall have a per diem rate set to reimburse 95 percent of base year costs.

(3) Hospitals with base year payment to cost ratios above 90 percent shall have a per diem rate set to reimburse 100 percent of base year costs.

C. Set facility specific per diem rates to reimburse the target payment to cost ratio as determined in B.

6.22 Transfer Payment for Minnesota and Local Trade Area Hospitals

Transfer Payment =	Standard payment (per diem), multiplied by the actual length of stay.

6.24 Out-of-Area Hospitals

Out-of-area Payment =	Statewide average wage-adjusted base rate, multiplied by the relative value, multiplied by the policy adjustment factor

A. Determine the average statewide wage-adjusted base rate for the APR-DRG discharge
B. Multiply by the relative value
C. Multiply by the policy adjustment factor

Payments to out-of-area hospitals may be established based on a negotiated rate if the Department contracts directly with the hospital. Payments, including third party liability, may not exceed the charges on a claim-specific basis for inpatient hospital services that are covered by Minnesota Medical Assistance.

6.25 Interim Payment Methodology

If the methodology described in this attachment cannot be implemented prior to July 1, 2021, the Department will employ an interim payment methodology.

The interim payment rate is equal to the rate in effect on July 1, 2020.

Upon implementation of the methodology described in this attachment, the Department shall reprocess all claims paid under the interim payment methodology.

SECTION 6.3 OTHER PAYMENT FACTORS

6.31 Charge limitation. Individual hospital payments, including DPA payments, established for Medical Assistance covered inpatient services in addition to third party liability for discharges occurring in a rate year will not exceed the billed charges on each claim.

6.32 Neonatal respiratory distress syndrome. For discharges to be paid under inpatient hospital rates that include the diagnosis of neonatal respiratory distress syndrome, services must be provided in a level II or above inpatient hospital nursery. Otherwise, payment will be determined by taking into account respiratory distress but not respiratory distress syndrome.

6.33 Non-payment for hospital-acquired or provider-preventable conditions. No payment will be made for the care, additional treatment or procedures, readmission to the hospital after discharge, increased length of stay, change to a higher diagnostic category, or transfer to another hospital when the charges are attributable to a hospital-acquired or provider-preventable condition. In the event of a transfer to another hospital, the hospital where the hospital-acquired or provider-preventable condition was acquired is responsible for any cost incurred at the hospital to which the patient with the condition is transferred.

6.34 Indian Health Service. Medical assistance payments to facilities of the Indian Health Service and facilities operated by a tribe or tribal organization under funding authorized by title I of the Indian Self-Determination and Education Assistance Act, Public Law Number 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, Public Law 106-260, or by United States Code, title 25, chapter 14, subchapter II, sections 450f to 450n, are excluded from the DRG system and are paid according to the rate published by the United States assistant secretary for health under authority of United States Code, title 42, sections 248A and 248B.

6.35 Psychiatric services contracts. The Commissioner has determined that there is a need for access to additional inpatient hospital psychiatric beds for persons with either serious emotional disturbance or serious and persistent mental illness, who have been civilly committed or voluntarily hospitalized, and can be treated and discharged within 45 days (or, effective August 1, 2005, additional days beyond 45 based on the Department's individual review of medical necessity). In response, contracts with non-state operated hospitals to provide inpatient hospital psychiatric services to patients who will be dually committed to the non-state operated hospital and the State-operated regional treatment center, or who have agreed to hospitalization, have been established. Payment rates for these inpatient psychiatric services are negotiated and established in the contracts executed under an open bidding process between the Commissioner and the hospitals.

A. Parameters related to the acceptance of a proposal other than cost include:

(1) the quality of the utilization review plan;

(2) experience with mental health diagnoses; and

(3) the commitment process.

B. Parameters related to acceptance of a proposal on a financial and cost basis include:

(1) payer of last resort/payment in full compliance assurances;

(2) general experience operating within the Medicare/Medical Assistance programs; and

(3) financial integrity.

C. Voluntary hospitalizations are included in the contracts: If the attending physician indicates that the patient is in need of continued mental health inpatient treatment and that the patient is competent to consent to treatment (or has a substitute decision maker with the authority to consent to treatment).

Rates are established through the bid process with negotiation based on the cost of operating the hospital's mental health unit as derived from the Medicare cost report. The cost information, for comparison to a state-operated hospital, is adjusted to take into account average acuity and length of stay differences.

6.36 Medical Education and Research Costs. In addition to Medical Assistance payments included in this Attachment, Medical Assistance provides for an additional annual payment according to the formula in Supplement 3 of this attachment. Effective for discharges on or after January 1, 2024, payments to each hospital and the affiliated clinics will be included in the payment rates for inpatient hospital services. Hospital systems may elect to have all MERC payments for each hospital and clinic within the system paid to a single hospital within the system. Payments made within the inpatient hospital rates shall be reconciled annually to ensure that total payments do not exceed the amounts determined in the formula in Supplement 3 of this attachment.

6.37 Newborn Screening Fee. Effective for admissions occurring on or after January 1, 2022, payment rates shall be adjusted to include the increase to the fee that is effective on January 1, 2022, for newborn screening tests required the Minnesota Department of Health that is paid by the hospital for Medical Assistance recipients. This payment increase shall be in effect until the increase is fully recognized within the base year cost.

SECTION 7.0 LONG-TERM HOSPITALS

7.01 Establishment of base years.

For the January 1, 2011, rebased rate year, rates for Minnesota long term hospitals (section 7.0) only will be rebased to the most recent hospital fiscal year ending on or before September 1, 2008, not including payments described in section 8.01 or section 7.45. Effective January 1, 2013, and after, rates for all long-term hospitals will not be rebased. For long-term hospitals that open after April 1, 1995, the base year is the year for which the hospital first filed a Medicare cost report.

Effective for discharges on or after July 1, 2019, rates for all Minnesota and Local Trade Area long term hospitals will be rebased. The base year will be updated (re-based) every two years to the most recent year for which filed, Medicare cost reports are available. The re-basing shall reflect changes in hospital costs between the existing base year and the next base year.

For every year that is not a re-basing year, payment rates shall be inflated using the Centers for Medicare & Medicaid Services' Inpatient Hospital Market Basket Index.

SECTION 7.2 CALCULATION OF PAYMENT RATES

7.21 Standard Payment for Minnesota and Local Trade Area Hospitals

Effective for discharges on or after July 1, 2023, payment rates shall be facility-specific, per diem payment rates. The per diem rates shall be based on a facility-specific percentage of costs as recorded on the most recently filed Medicare Cost Report as of December 2021 for the cost reporting period ending in 2019. The calculated cost based rate shall be the final rate and will not be settled to actual, incurred costs.

Standard Payment =	Covered Days multiplied by facility-specific per diem rate.

A. Calculate a payment-to-cost ratio using allowable cost and revenue data from Medicare Cost Report

B. Determine payment-to-cost ratio tier

(1) Hospitals with base year payment-to-cost ratios at or below 80 percent shall have a per diem payment rate set to reimburse 85 percent of base year costs.
(2) Hospitals with base year payment to cost ratios above 80 percent up to and including 90 percent shall have a per diem rate set to reimburse 95 percent of base year costs.

(3) Hospitals with base year payment to cost ratios above 90 percent shall have a per diem rate set to reimburse 100 percent of base year costs.

C. Set facility specific per diem rates to reimburse the target payment to cost ratio as determined in B. Compare the facility specific rate in C with the facility specific rate effective June 30, 2023. The final rate will be the higher of the computed rate or the rate in effect on June 30, 2023.

7.22 Transfer Payment for Minnesota and Local Trade Area Hospitals

Transfer Payment =	Standard payment (per diem), multiplied by the actual length of stay.

7.24 Out-of-Area Hospitals

Out-of-area Payment =	Statewide average wage-adjusted base rate, multiplied by the relative value, multiplied by the policy adjustment factor

A. Determine the average statewide wage-adjusted base rate for the APR-DRG discharge
B. Multiply by the relative value
C. Multiply by the policy adjustment factor

Payments to out-of-area hospitals may be established based on a negotiated rate if the Department contracts directly with the hospital. Payments, including third party liability, may not exceed the charges on a claim-specific basis for inpatient hospital services that are covered by Minnesota Medical Assistance.

7.25 Interim Payment Methodology

If the methodology described in this attachment cannot be implemented prior to July 1, 2023, the Department will employ an interim payment methodology.

The interim payment rate is equal to the rate in effect on July 1, 2020.

Upon implementation of the methodology described in this attachment, the Department shall reprocess all claims paid under the interim payment methodology.

SECTION 7.2 RATEABLE ADJUSTMENTS

7.21 Reserved

7.22 Reserved

7.23 Reserved

7.24 Reserved

7.25 Reserved

7.26 Reserved

7.27 Reserved

7.28 Reserved

7.29 Hearing detection fee increase. Effective for admissions occurring on or after July 1, 2010, payment rates shall be adjusted to include the increase to the fee that is effective on July 1, 2010, for the early hearing detection and intervention program recipients under Minnesota Statutes §141.125, subdivision 1, that is paid by the hospital for Medical Assistance recipients. This payment increase shall be in effect until the increase is fully recognized within the base year cost.

Effective for admissions occurring on or after July 1, 2013, payment rates shall be adjusted to include the increase to the fee that is effective on July 1, 2013, for the early hearing detection and intervention program recipients under Minnesota Statutes §144.125, subdivision 1, paragraph (d) that is paid by the hospital for Medical Assistance recipients. This payment increase shall be in effect until the increase is fully recognized within the base year cost.

7.291 Reserved

SECTION 7.3 (Reserved)

SECTION 7.4 OTHER PAYMENT FACTORS

7.41 Charge limitation. Individual hospital payments, including DPA payments, established for Medical Assistance covered inpatient services in addition to third party liability for discharges occurring in a rate year will not exceed the billed charges on the claim.

7.42 Non-payment for hospital-acquired and provider-preventable conditions. No payment will be made for the care, additional treatment or procedures, readmission to the hospital after discharge, increased length of stay, change to a higher diagnostic category, or transfer to another hospital when the charges are attributable to a hospital-acquired or provider-preventable condition. In the event of a transfer to another hospital, the hospital where the hospital-acquired or provider-preventable condition was acquired is responsible for any cost incurred at the hospital to which the patient with the condition is transferred.

7.43 Indian Health Service. Medical assistance payments to facilities of the Indian Health Service and facilities operated by a tribe or tribal organization under funding authorized by title I of the Indian Self-Determination and Education Assistance Act, Public Law Number 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, Public Law 106-260, or by United States Code, title 25, chapter 14, subchapter II, sections 450f to 450n, are excluded from the DRG system and are paid according to the rate published by the United States assistant secretary for health under authority of United States Code, title 42, sections 248A and 248B.

7.44 Medical Education and Research Costs. In addition to Medical Assistance payments included in this Attachment, Medical Assistance provides for an additional annual payment according to the formula in Supplement 3 of this attachment. Effective for discharges on or after January 1, 2024, payments to each hospital and the affiliated clinics will be included in the payment rates for inpatient hospital services. Hospital systems may elect to have all MERC payments for each hospital and clinic within the system paid to a single hospital within the system. Payments made within the inpatient hospital rates shall be reconciled annually to ensure that total payments do not exceed the amounts determined in the formula in Supplement 3 of this attachment.

7.46 Reserved

SECTION 7.5 RESERVED

SECTION 8.0 DISPROPORTIONATE POPULATION ADJUSTMENT

8.01 Disproportionate population adjustment or DPA eligibility. A Minnesota hospital that is not state-owned, not a facility of the federal Indian Health Service, and not a critical access hospital and that meets the criteria of items A to C is eligible for an adjustment to the payment rate.

A. A hospital must have at least two obstetricians with staff privileges who have agreed to provide obstetric services to Medical Assistance recipients. For non-MSA hospitals the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

B. A hospital that did not offer non-emergency obstetric services as of December 21, 1987 or a hospital whose inpatients are predominately under 18 years of age is not subject to item A.

C. A hospital must have a base year Medical Assistance inpatient utilization rate that exceeds 1 percent.

MA Inpatient Utilization Rate (MIUR) =	Medical Assistance inpatient days, divided by total inpatient days

8.02 Disproportionate population adjustment factors. Eligible hospitals that are not licensed children's hospitals may qualify for the contract bed factor, the transplant hospital factor and one of three volume factors.

A. Contract Bed Factor – a hospital that has a contract with the Department to provide extended inpatient psychiatric services in the rate year shall have a factor of 0.0160.
B. Transplant Factor – a hospital that has received Medical Assistance payment for at least 20 transplant services in the base year shall have a factor of 0.0435.
C. Volume Factor
   i. Hospitals with an MIUR in the base year of at least 20 percent up to one standard deviation above the statewide mean shall have a factor of 0.0468.
   ii. Hospitals with an MIUR in the base year that is at least one standard deviation above the statewide mean, but less than three standard deviations above the statewide mean shall have a factor of 0.2300.
   iii. Hospitals with an MIUR in the base year that is more than two and one

Quarter standard deviations above the statewide mean shall have a factor of 0.3711.

D. Final DPA Factor – the final DPA factor for hospitals qualifying under this section is equal to one plus the sum of A through C.

Final DPA Factor =	1 + (Contract Bed factor + Transplant factor + Volume factor + Safety Net factor)

8.03 Disproportionate population adjustment factors – children's hospitals. Eligible hospitals that are licensed children's hospitals may qualify for one DPA factor based on the number of fee-for-service Medical Assistance discharges in the base year.

A. Licensed children's hospitals with at least 1,000 fee-for-service discharges in the base year shall have a factor equal to 1.868.
B. Licensed child0000ren's hospitals with fewer than 1,000 fee-for-service discharges in the base year shall have a factor equal to 1.7880.

The applicable DPA factor (from A or B) plus the applicable factor from section 8.04 is the final DPA factor for the qualifying children's hospital.

8.04 Disproportionate population adjustment factors – safety net hospitals. Eligible Children's and non-children's hospitals that are designated as essential safety net hospitals may qualify for a DPA factor in addition to the factors in 8.02 and 8.03.

8.05 Limitation on DPA payment amounts. In the event that DPA payments to a qualifying hospital exceed the facility-specific DSH limit for the hospital for the applicable DSH year, the DPA payment to the hospital will be limited to the facility-specific DSH limit.

Payments in excess of the applicable facility specific DSH limit shall be returned to the Department for redistribution to qualifying hospitals.

8.06 Redistribution of Returned DPA amounts. Excess DPA payments that are returned to the Department in accordance with section 8.05 shall be redistributed to qualifying hospitals. Hospitals qualified to accept redistributed DPA funding must:

A. Be eligible to receive DPA payments under section 8.01;
B. Be eligible to receive DPA payments under section 8.02 and have a volume factor as described paragraphs C(ii) or C(iii); and

C. Not have exceeded the limit in section 8.05

Returned DPA funding shall be distributed to qualifying hospitals based on each hospital's Medical Assistance fee-for-service discharges expressed as a percentage of the total Medical Assistance fee-for-service discharges of all of the hospitals qualified to receive additional DPA payments under this section.

The final redistributed DPA payment amount to a receiving hospital may not result in total DPA payments to that hospital exceeding the limit in section 8.05.

Final Redistributed DPA Payment Amount =	Lesser of: The difference between the amount paid in accordance with section 8.02 and 8.04 and the limit in section 8.05, Or The amount equal to the total amount of DPA funding to be redistributed, multiplied by (the hospital's number of fee-for-service MA discharges divided by the total number of fee-for-service MA discharges of all of the hospitals eligible to receive redistributed DPA funds in the rate year).

SECTION 9.0 PAYMENT PROCEDURES

9.01 Submittal of Claims. Hospital final billings under the Medical Assistance program cannot be submitted until the recipient is discharged. However, the Department establishes monthly interim payments for hospitals that have recipient lengths of stay over 30 days regardless of the diagnostic category.

9.02 Readmission. An admission and readmission to the same or a different hospital within 15 days, not including the day of admission and the day of discharge, is eligible for payment according to criteria that determines whether the admission and readmission are paid as one admission, two admissions or as transfers. (Outlier payments are paid when applicable.)

A. An admission and readmission are paid as two admissions when the recipient's discharge from the first admission and subsequent readmission are medically appropriate according to prevailing medical standards, practice and usage. An admission and readmission are also paid as two admissions when the reason for the readmission is the result of:

   (1) A recipient leaving the hospital of the first admission against medical advice;

   (2) A recipient being noncompliant with medical advice that is documented in the recipient's medical record as being given to the recipient; or

   (3) A recipient having a new episode of an illness or condition.

B. An admission and readmission are paid as a combined admission if they occur at the same hospital, or as transfer payments if they occur at different hospitals, when a recipient is discharged from the first admission without receiving medically necessary treatment because of:

   (1) Hospital or physician scheduling conflict;

   (2) Hospital or physician preference other than medical necessity;

   (3) Patient preference; or

   (4) Referral.

C. When a readmission occurs as a result of an inappropriate discharge from the first admission, the first admission will be denied payment and the readmission will be considered a separate admission.

[Reserved]

~~**Methods and Standards for Determining Payment Rates for Inpatient Hospital Services in the General Assistance Medical Care (GAMC) Program, in Accordance with Section 13.06 of Attachment 4.19-A.**~~

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~~SECTION 1.0 PURPOSE AND SCOPE~~

~~For purposes of this supplement, all references to Medical Assistance or MA means General Assistance Medical Care or GAMC. The Minnesota inpatient hospital payment system under the Medical Assistance Program is authorized by state law. Payment rates are prospectively established on a per admission or per day basis under a diagnostic related group (DRG) system that condenses Medicare categories into Minnesota diagnostic categories. An additional rate is established for hospitals that provide rehabilitation distinct part specialty services. The system provides for the payment of operating and property costs with additional payments including a disproportionate population adjustment and an appeals mechanism.~~

~~The rate setting methodology is based on the cost finding and allowable cost principles of the Medicare program. The rates are established for each calendar year using hospital specific Medical Assistance claims data and cost that is trended for inflation to the current year from a base year. Rates are rebased to more current data every two years.~~

~~The methodology described in this Attachment is effective for admissions occurring on or after October 25, 1993.~~

~~To be eligible for payment, inpatient hospital services must be medically necessary.~~

~~Minnesota has in place a public process that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.~~

~~SECTION 2.0 DEFINITIONS~~

~~Accommodation service.~~ ~~"Accommodation service" means those inpatient hospital services included by a hospital in a daily room charge. They are composed of general routine services and special care units. These routine and special care units include the nursery, coronary, intensive, neonatal, rehabilitation, psychiatric, and chemical dependency units.~~

~~Admission.~~ ~~"Admission" means the time of birth at a hospital or the act that allows a recipient to officially enter a hospital to receive inpatient hospital services under the supervision of a physician who is a member of the medical staff.~~

~~Allowable base year operating cost.~~ ~~"Allowable base year operating cost" means a hospital's base year inpatient hospital cost per admission or per day that is adjusted for case mix and excludes property costs.~~

~~Ancillary service.~~ ~~"Ancillary service" means inpatient hospital services that include laboratory and blood, radiology, anesthesiology, electrocardiology, electroencephalography, pharmacy and intravenous therapy, delivery and labor room, operating and recovery room, emergency room~~

~~and outpatient clinic, observation beds, respiratory therapy, physical therapy, occupational therapy, speech therapy, medical supplies, renal dialysis, and psychiatric and chemical dependency services customarily charged in addition to an accommodation service charge.~~

~~**Base year.** "Base year" means a hospital's fiscal year that is recognized by Medicare, or a hospital's fiscal year specified by the commissioner if a hospital is not required to file information with Medicare, from which cost and statistical data are used to establish rates.~~

~~**Case mix.** "Case mix" means a hospital's admissions distribution of relative values among the diagnostic categories.~~

~~**Charges.** "Charges" means the usual and customary payment requested by the hospital of the general public.~~

~~**City of the first class.** "City of the first class" means a city that has more than 100,000 inhabitants, provided that once a city is defined in such a manner, it can not be reclassified unless its population decreases by 25 percent from the census figures that last qualified the city for inclusion in the class.~~

~~**Cost outlier.** "Cost outlier" means the adjustment included in the relative value that is applied to the admission and outlier rates so that payment is adjusted for exceptionally high cost stays. The adjustment is applied to all admissions with an above average cost, including patients that have not yet attained the age of one in all hospitals and that have not yet attained the age of six in disproportionate population hospitals.~~

~~**Cost-to-charge ratio.** "Cost-to-charge ratio" means a ratio of a hospital's inpatient hospital costs to its charges for inpatient hospital services.~~

~~**Day outlier.** "Day outlier" means an admission where the length of stay exceeds the mean length of stay for neonate and burn diagnostic categories by one standard deviation, and in the case of all other diagnostic categories by two standard deviations.~~

Diagnostic categories. "Diagnostic categories" means the diagnostic classifications containing one or more diagnostic related groups (DRGs) used by the Medicare program. The DRG classifications must be assigned according to the base year for routine inpatient hospital services and the rehabilitation distinct part specialty group with modifications as specified in items A to C.

A. Diagnostic categories for GAMC

GAMC Diagnostic Categories

Diagnostic categories for persons eligible under the general assistance medical care program. The following diagnostic categories are for persons eligible under the general assistance medical care program except as provided in subpart 20e or 20f:

DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTERNATIONAL CLASSIFICATION OF DISEASES, 9th Ed., CLINICAL MODIFICATIONS CODES
A. Nervous System Conditions		
(1) Intracranial vascular procedures with principal diagnosis of hemorrhage	528	
(2) Craniotomy except craniotomy without CC	001, 003, 484, 531, 543	
(3) Ventricular shunt and extracranial procedures with CC and acute stroke with thrombolytic agent	529, 533, 559	
(4) Other neurological O.R. procedures or intracranial hemorrhage, cerebral infarct, and nervous system neoplasms	002, 007, 008, 014 020, 530, 532, 534	
(5) Spinal disorders and injuries, encephalopathy, cerebrovascular disorder, stupor & coma with CC	009, 016, 022, 028	
(6) Nervous system neoplasms with CC; Degenerative disorders, precerebral occlusion and other specified disorders	010, 012, 015, 021, 027, 034	
(7) Seizure and headache except with CC or specified stupor and coma	017, 023, 024, 026, 029, 030	
(8) Concussion and other nervous system diseases and disorders	011, 013, 018, 019, 025,	

~~with and without CC — 031-033, 035, 524~~

~~B. Eye Diseases and Disorders — 036-048~~

~~C. Ear, Nose, Throat, and Mouth Diseases and Disorders~~
~~(1) Major head and ENT procedures — 049, 050, 053, 054, 056, 059, 063~~
~~(2) Other ear, nose, throat, and mouth procedures — 051, 052, 055, 057, 058, 060-062, 064, 185-187~~
~~(3) Epiglottis, Laryngotracheitis, and Other ENT conditions — 067, 069, 071-073~~
~~(4) Disequilibrium, Epitaxis, Otitis media and URI except without CC — 065, 066, 068, 070, 074~~

~~D. Respiratory System Conditions~~
~~(1) Treated with ventilator support for < 96 hrs — 475 — excludes procedure 96.72~~
~~(2) Treated with ventilator support for 96+ hours — 475 — includes procedure 96.72~~
~~(3) [Reserved for future use]~~
~~(4) P.E., Respiratory infections, Neoplasms, Pleural effusion, Pulmonary edema, and Respiratory failure, and other conditions with CC — 078-083, 085, 087, 092, 094, 101~~
~~(5) COPD, Pneumonia, Pneumothorax, Bronchitis and Other respiratory system conditions without CC — 086, 088, 091, 093, 095-099, 102~~
~~(6) Major chest trauma and Respiratory signs and symptoms without CC — 84, 100~~
~~(7) Tracheostomy for face, mouth and neck diagnoses and Full thickness burns — 482, 508~~
~~(8) Major chest and other surgical procedure — 075-077~~

~~E. Circulatory System Conditions~~
~~(1) [Reserved for future use]~~
~~(2) [Reserved for future use]~~
~~(3) [Reserved for future use]~~
~~(4) Valve replacement with cath, CABG with PTCA, and AICD implant with AMI, heart failure and shock — 104, 106, 535-536~~
~~(5) Major cardio-thoracic and vascular procedures — 105, 108, 110, 113, 515, 547, 553~~
~~(6) Other cardiac and circulatory surgeries and percutaneous procedures including drug-eluding stents — 111, 120, 548-552, 554-555, 557, 558~~
~~(7) Procedures for circulatory disorders, Cardiac pacemaker revision or replacement, and Acute MI, heart failure and shock, and Endocarditis — 114, 117, 118, 121, 123, 124, 126, 518, 556~~
~~(8) Heart failure & shock Other circulatory disorders with CC and~~

~~Vascular procedures without CC 127, 129-130, 144, 479~~
~~(9) Vein ligation and stripping, Circulatory disorders with cath without CC 119, 125~~
~~(10) Uncomplicated AMI and Other circulatory system diagnoses without CC 122, 145~~
~~(11) Cardiac arrhythmias, Valve disorders, and Hypertension 131, 134-138~~
~~(12) Thrombophlebitis, Atherosclerosis, Angina, and Syncope 128, 132, 133, 139-142~~
~~(13) Chest pain 143~~

~~F. Digestive System Diseases and Disorders~~
~~(1) Major bowel, stomach, esophagus, and duodenal surgery with CC 146, 148, 154~~
~~(2) Minor bowel and Other digestive system surgeries with CC 150, 152, 156, 170~~
~~(3) Major bowel procedures without CC and Other digestive system procedures with CC 147, 149, 157, 164, 188~~
~~(4) Appendectomy w/out complicating principal diagnoses, Stomal & Hernia procedures 158, 160-163, 166-169~~
~~(5) Treated with other surgical procedure 151, 153, 155, 159, 165, 171~~
~~(6) GI hemorrhage with CC and other digestive system diagnoses, age 0-17 174, 190~~
~~(7) Uncomplicated peptic ulcer and Other digestive system diseases 172, 177,180, 189~~
~~(8) Miscellaneous digestive disorders with CC and Digestive malignancy without CC 173, 182~~
~~(9) GI Hemorrhage and Obstruction without CC and Miscellaneous disorders except CC 175, 176, 181, 183, 184~~

~~G. Hepatobiliary System Conditions~~
~~(1) Pancreas, Liver, Shunt, and Hepatobiliary procedures 191, 193, 199, 201~~
~~(2) Cholecystectomy except laparoscopic and Diagnostic hepatobiliary procedures 194, 195, 197, 198, 200~~
~~(3) Cirrhosis and alcoholic hepatitis and Other liver disorders with CC 202, 205~~
~~(4) Pancreas, liver, shunt procedures without CC and Biliary procedures with CC 192, 196, 493~~
~~(5) Lap cholecystectomy without CC 494~~
~~(6) Other disorders of liver and Pancreas and Hepatobiliary malignancy 203, 204, 206~~
~~(7) Disorders of biliary tract 207, 208~~

~~H. Diseases and Disorders of the Musculoskeletal System and Connective Tissues~~
~~(1) Major and high resource utilization surgery: Kidney transplant, Limb reattachment and Hip & femur surgery for trauma, Spinal fusion for curvature or malignancy 302, 485, 546~~
~~(2) Surgery on Hip & Femur, Multiple Joints, and Knee and Spinal Fusion 210, 471, 496, 497, 501~~

(3) Muscular system and connective tissue surgery and Wound debridement — 217, 233
(4) Musculoskeletal disorder with Major O.R. procedure or O.R. without CC on lower extremity, hip, and spine — 212, 226, 498, 519, 537, 545
(5) Lower extremity Amputation, Joint replacement, and Reattachment and Biopsy of Musculoskeletal tissue — 213, 216, 218, 285, 544
(6) Other surgery on Hip, Lower extremity and Spine — 225, 230, 491, 502, 520
(7) Minor lower extremity joint without CC and Major upper extremity joint procedure with CC — 211, 219, 223, 228, 234
(8) Upper extremity procedures, Knee procedures without PDx of infection, and Removal of fixation device — 220, 224, 503, 538
(9) Back and neck procedures except fusion, Arthroscopy, and Connective tissue disorders — 232, 240, 241, 499, 500
(10) Pathological fracture and Musculoskeletal and Connective tissue malignancy — 238, 239, 256
(11) Soft tissue procedures, Fractures Injuries, Sprains and strains — 227, 235, 236, 244, 250, 255
(12) Medical back problems and Other diseases and disorders — 237, 242, 243, 245 248
(13) Aftercare, musculoskeletal system and connective tissue — 249, 252, 253
(14) Injury to extremities without CC — 251, 254
(15) [Reserved for future use]
(16) [Reserved for future use]
(17) [Reserved for future use]
(18) [Reserved for future use]
(19) Hand and wrist procedures and Carpal tunnel release — 006, 229, 441

I. Diseases and Disorders of the Skin, Subcutaneous Tissue, and Breast
(1) Treated with skin graft and/or debridement — 263, 265, 287
(2) Malignant breast disorders with CC — 266, 268, 270, 274
(3) Other skin, subcutaneous tissue and Breast procedure with CC — 264, 269
(4) Breast biopsy and mastectomy — 257-260, 262, 277
(5) Other skin, subcutaneous tissue, and breast conditions — 261, 267, 272, 276, 281, 283
(6) Skin ulcers and Cellulitis — 271, 279, 280, 282
(7) Malignant breast disorders without complication — 273, 275, 278, 284

J. Endocrine, Nutritional, and Metabolic Diseases and Disorders
(1) Major surgical procedures — 286, 288, 290-293
(2) Diabetes age > 35 and Inborn errors of metabolism — 294, 299

~~(3) Diabetes age 0-35 — 295~~
~~(4) Endocrine, Nutritional and metabolic disorders — 289, 296~~
~~(5) Endocrine disorders with CC — 300~~
~~(6) Other endocrine, nutritional, and metabolic conditions except with CC — 297, 298, 301~~

~~K. Kidney and Urinary Tract Conditions~~
~~(1) Kidney, ureter, and major bladder procedures — 303, 304, 308, 315~~
~~(2) [Reserved for future use]~~
~~(3) KUB procedures without CC and Prostatectomy with CC — 305, 306~~
~~(4) Other kidney and urinary tract procedures without CC and diagnoses with CC — 307, 309, 310, 317, 319, 320, 331~~
~~(5) Kidney and urinary tract infection except with CC and Urethral procedures — 311-314, 321-323~~
~~(6) Renal Failure, Neoplasms and Urethral stricture with CC — 316, 318, 328, 333~~
~~(7) Other kidney and urinary tract conditions — 324-327, 329, 330, 332~~

~~L. Male Reproductive System Conditions~~
~~(1) Major surgery — 334, 335, 338-340, 344, 345~~
~~(2) Other medical and surgical treatments — 336, 337, 341-343, 346-352~~

~~M. Female Reproductive System Conditions~~
~~(1) Tubal interruption, D & C, Malignancy without CC, and Infection — 362, 364, 367, 368~~
~~(2) [Reserved for future use]~~
~~(3) [Reserved for future use]~~
~~(4) Malignancy with CC, other disorders and Reconstructive procedures — 356, 359, 366, 369~~
~~(5) Pelvic evisceration and Surgery for ovarian malignancy — 353, 357~~
~~(6) Uterine, Adnexa, and other OR procedures — 354, 355, 358, 360, 361, 363, 365~~

~~N. Pregnancy and Related Conditions~~
~~(1) Cesarean section and Postpartum complications with surgery — 370, 371, 377~~
~~(2) Vaginal delivery and Other pregnancy related conditions and procedures — 372-376, 378-384~~
~~O. [Reserved for future use]~~

~~P. Blood and Immunity Disorders~~
~~(1) Surgical procedure of the blood and blood forming organs and Coagulation disorders — 392-394, 397~~
~~(2) RBC and Reticuloendothelial and Immunity disorders — 395, 396, 398, 399~~

~~Q. Myeloproliferative Diseases and Disorders, Poorly Differentiated Malignancy and Other Neoplasms~~

~~(1) [Reserved for future use]~~
~~(2) [Reserved for future use]~~
~~(3) Surgical and other treatment for myeloproliferative diseases and disorders — 401-403, 405, 406, 408, 473, 492, 539, 540~~
~~(4) Lymphoma, Leukemia, Radiotherapy and Chemotherapy — 404, 407, 409-414~~

~~R. Infections and Parasitic Diseases~~

~~(1) Treated with surgical procedure — 415~~
~~(2) Septicemia and Other infections and parasitic diseases — 416, 417, 423~~
~~(3) Postop and post traumatic infections — 418~~
~~(4) Viral illness and Fever of unknown origin — 419-422~~
~~(5) [Reserved for future use]~~

~~S. Mental Diseases and Disorders~~

~~(1) Principal diagnosis of mental illness with surgery — 424~~
~~(2) Adjustment reaction and Other mental disorders — 425, 432~~
~~(3) Depressive neuroses and Childhood mental disorders — 426, 431~~
~~(4) Other psychiatric diseases and disorders — 427, 428, 429~~
~~(5) Psychoses — 430~~

~~T. Substance Use and Substance Induced Organic Mental Disorders~~

~~(1) With CC — 521 — DRG 521 excludes procedures 94.61, 94.63, 94.64, 94.66, 94.67, 94.69~~
~~(2) Without rehab, without CC — 523~~

~~U. [Reserved for future use]~~

~~V. Injuries, Poisonings, and Toxic Effects of Drugs~~

~~(1) Treated with Skin grafts and Other surgical procedures for injuries with CC — 439, 442~~
~~(2) Wound debridement and Other surgery for injuries without CC — 440, 443~~
~~(3) Traumatic injury — 444-446~~
~~(4) Allergic reactions — 447, 448, 453~~
~~(5) Poisoning and toxic effects of drugs, age >17 with CC — 449~~
~~(6) Poisoning and toxic effects of drugs age >17 without CC and age 0-17 — 450, 451~~
~~(7) [Reserved for future use]~~
~~(8) Other injuries and toxic effects and Complications of treatment with CC — 452, 454, 455~~

~~W. Burns~~
~~(1) Third degree burn without skin graft, without complication and Nonextensive burns 509-511~~
~~(2) [Reserved for future use]~~
~~(3) Full thickness with CMV 96+ hrs without graft and Without CMV with graft 505, 507~~

~~X. Factors Influencing Health Status~~
~~(1) O.R. procedures with diagnosis of other contact with health services 461~~
~~(2) Rehabilitation, Aftercare, and Signs and symptoms 462-467~~

~~Y. [Reserved for future use]~~
~~Z. [Reserved for future use]~~
~~AA. [Reserved for future use]~~
~~BB. [Reserved for future use]~~
~~CC. [Reserved for future use]~~
~~DD. [Reserved for future use]~~
~~EE. [Reserved for future use]~~
~~FF. [Reserved for future use]~~
~~GG. [Reserved for future use]~~
~~HH. [Reserved for future use]~~

~~II. Operating Room Procedure Unrelated to Principal Diagnosis~~
~~(1) Extensive 468~~
~~(2) Nonextensive 476, 477~~

~~JJ. [Reserved for future use]~~
~~KK. [Reserved for future use]~~
~~LL. [Reserved for future use]~~
~~MM. [Reserved for future use]~~
~~NN. [Reserved for future use]~~

~~OO. Multiple Significant Trauma~~
~~(1) Third degree burn with graft or inhalation injury with CC and Other surgery for multiple significant trauma 486, 506~~
~~(2) Multiple significant trauma without surgery 487~~

~~PP. [Reserved for future use]~~
~~QQ. [Reserved for future use]~~
~~RR. [Reserved for future use]~~
~~SS. [Reserved for future use]~~
~~TT. [Reserved for future use]~~

~~UU. ECMO/Tracheostomy with ventilator 96+ hours, Organ and Cell transplants, and Heart assist system implant 103, 480, 481, 495, 504, 512, 513, 525, 541, 542~~

~~VV. [Reserved for future use]~~

~~WW. Human Immunodeficiency Virus 488-490~~

~~B. **Diagnostic categories relating to a rehabilitation hospital or a rehabilitation distinct part.** The following diagnostic categories are for services provided within a rehabilitation hospital or a rehabilitation distinct part:~~

~~DIAGNOSTIC CATEGORIES~~	~~DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES~~	~~INTERNATIONAL CLASSIFICATION OF DISEASES, 9th Ed. CLINICAL MODIFICATIONS~~
~~A. Nervous System Diseases and Disorders~~	~~001-003, 006-035, 524, 524, 528-534, 543, 559~~	~~except codes in category Y and Z~~
~~B. [Reserved for future use]~~		
~~C. [Reserved for future use]~~		
~~D. [Reserved for future use]~~		
~~E. [Reserved for future use]~~		
~~F. [Reserved for future use]~~		
~~G. [Reserved for future use]~~		
~~H. Diseases and Disorders of the Musculo-skeletal System and Connective Tissue~~	~~210-213, 216-220, 223, 230, 232-256, 471, 491, 496-503, 519, 520, 537, 538, 544-546~~	~~except codes in category Y and Z~~
~~I. [Reserved for future use]~~		
~~J. [Reserved for future use]~~		
~~K. [Reserved for future use]~~		
~~L. [Reserved for future use]~~		
~~M. [Reserved for future use]~~		
~~N. [Reserved for future use]~~		
~~O. [Reserved for future use]~~		
~~P. [Reserved for future use]~~		
~~Q. [Reserved for future use]~~		
~~R. Mental Diseases and Disorders/Substance Use and Substance Induced Organic Mental Disorders~~	~~424-432, 521, 523~~	~~except codes in category Y and Z; DRG 521 excludes procedures 94.61, 94.61, 94.63, 94.64, 94.66, 94.67, 94.69~~
~~S. Multiple Significant Trauma/ Unrelated Operating Room Procedures~~	~~468, 476, 477,~~	~~except codes in category Y and Z~~
~~T. Other Conditions Requiring Rehabilitation~~		

~~Services~~	~~036-106, 108, 110, 111, 113, 114, 117-208, 257-399, 401-423, 439-455, 461-467, 473, 475, 479-482, 488-490, 492-495, 504-513, 515, 518, 525, 535, 536, 539, 540-542, 547-558~~	~~except codes in category Y & Z~~
~~U. [Reserved for future use]~~		
~~V. [Reserved for future use]~~		
~~W. [Reserved for future use]~~		
~~X. [Reserved for future use]~~		
~~Y. Specific late effects or conditions secondary to a spinal cord or intracranial injury or skull fracture which result in paraplegia~~	~~All DRGs~~	~~Diagnosis codes 344.1, 806.21, 806.26 806.31, 806.36, 952.11, 952.16 in combination with 905.0, 907.0, or 907.2, excluding cases with 781.0, 781.2, 781.3, & 781.4~~
~~Z. Specific late effects or conditions secondary to a spinal cord or intracranial injury or skull fracture which result in quadriplegia or hemiplegia~~	~~All DRGs~~	~~Diagnosis codes 344.01-344.04, 344.09, 806.0x, 806.1x, or 952.0x in combination with 907.2, excluding cases with 781.0, 781.2, & 780.03; or Diagnosis codes 344.00-344.04, 344.09, 342.01, 342.81, or 342.91 in combination with 907.0 or 905.0, excluding cases 781.0, 781.3, & 780.03~~

~~**C. Additional DRG requirements.**~~

~~1. Version 23 of the Medicare grouper and DRG assignment to the diagnostic category must be used uniformly for all determinations of rates and payments.~~

~~2. The discharge status will be changed to "discharge to home" for DRG 433.~~

~~3. A principal diagnosis with the prefix "v57" will be excluded when grouping under item B.~~

~~4. The discharge status will be changed to "discharge to home" when grouping under item A for a transfer to a Medicare rehabilitation distinct part.~~

~~5. A transfer from a hospital paid under a diagnostic category in item A, which includes ICD-9-CM procedure code 86.06 (implantation of a totally implantable infusion pump) for the treatment of spasticity, to a Medicare rehabilitation distinct part must include ICD-9-CM~~

~~diagnosis code 781.0 when grouping under item B.~~

~~6. For payment of admissions that result from the unavailability of a home health nurse, and there is one or more acute episodes of illness during the admission resulting in changes in physician orders and the treatment plan, the principal diagnoses V58.89, Other Specified Aftercare and V63.1, Medical Services in Home not Available will be excluded.~~

~~7. For payment under DRG 521, alcohol/drug abuse or dependence with complications or comorbidities, payment is not made for patients engaged in alcohol and/or drug rehabilitation.~~

~~8. For DRG 003, the patient age will be changed to 18 years. If the admission subsequently groups to DRG 529 or 530, that DRG will be assigned. Otherwise the admission will remain in DRG 003.~~

~~9.~~

~~**Hospital-acquired condition.** "Hospital-acquired condition" means a condition listed below that is not identified by the hospital as present on admission and is designated as a complicating condition or major complicating condition:~~

	ICD-9-CM
1. Foreign object accidentally retained after surgery	998.4, 998.7
2. Air embolism	999.1
3. Blood incompatibility reaction	999.6
4. Pressure ulcers stage III or IV	707.23, 707.24
5. Falls and trauma including fracture, dislocation, intracranial injury, crushing injury, burn, and electric shock	800-829, 830-839, 850-854 925-929, 940-949, 991-994
6. Catheter-associated urinary tract infection	996.64
7. Vascular catheter-associated infection	999.31
8. Manifestations of poor glycemic control	249.10, 249.11, 249.20,249.21 250.10-250.13, 250.20-250.23 251.0
9. Surgical site infection following orthopedic procedures	Dx 996.67, 998.59 Proc 81.01-81.08, 81.23-81.24, 81.31-81.38 81.83, 81.85
10. Surgical site infection following bariatric surgery	Dx 998.59 44.38-44.39, 44.95 for Principal Dx 278.01
11. Surgical site infection, mediastinitis following coronary artery bypass graft surgery	Dx 519.2 Proc 36.10-36.19
12. Deep vein thrombosis or pulmonary embolism following total knee or hip replacement	Dx 453.40-453.42, 415.11, 415.19 Proc 81.54, 00.85-00.87, 81.51-52

~~**Inpatient hospital costs.** "Inpatient hospital costs" means a hospital's base year inpatient hospital service costs determined allowable under the cost finding methods of Medicare but not~~

~~to include the Medical Assistance hospital surcharge and without regard to adjustments in payments imposed by Medicare.~~

~~**Inpatient hospital service.** "Inpatient hospital service" means a service provided by or under the supervision of a physician after a recipient's admission to a hospital and furnished in the hospital, including outpatient services provided by the same hospital that directly precede the admission.~~

~~**Local trade area hospital.** "Local trade area hospital" means a MSA hospital with 20 or more Medical Assistance (including General Assistance Medical Care, a State-funded program) admissions in the base year that is located in a state other than Minnesota, but in a county of the other state in which the county is contiguous to Minnesota.~~

~~**Long-term care hospital.** "Long-term care hospital" means a Minnesota hospital or a metropolitan statistical area hospital located outside Minnesota in a county contiguous to Minnesota that meets the requirements under Code of Federal Regulations, title 42, part 412, section 23(e).~~

~~**Metropolitan statistical area hospital or MSA hospital.** "Metropolitan statistical area hospital" or "MSA hospital" means a hospital located in a metropolitan statistical area as determined by Medicare for the October 1 prior to the most current rebased rate year.~~

~~**Non-metropolitan statistical area hospital or non-MSA hospital.** "Non-metropolitan statistical area hospital" or "non-MSA hospital" means metropolitan statistical area as determined by Medicare for the October 1 prior to the most current rebased rate year.~~

~~**Operating costs.** "Operating costs" means inpatient hospital costs excluding property costs.~~

~~**Out-of-area hospital.** "Out-of-area hospital" means a hospital that is located in a state other than Minnesota excluding MSA hospitals located in a county of the other state in which the county is contiguous to Minnesota.~~

~~**Property costs.** "Property costs" means inpatient hospital costs not subject to the hospital cost index, including depreciation, interest, rents and leases, property taxes, and property insurance.~~

~~**Rate year.** "Rate year" means a calendar year from January 1 through December 31.~~

~~**Rehabilitation distinct part.** "Rehabilitation distinct part" means inpatient hospital services that are provided by a hospital in a unit designated by Medicare as a rehabilitation distinct part.~~

~~**Relative value.** "Relative value" means the mean operating cost within a diagnostic category divided by the mean operating cost in all diagnostic categories within item A or B. The relative value is calculated from the total allowable operating costs of all admissions. This includes the~~

~~full, untruncated costs of all exceptionally high cost or long stay admissions. Due to this inclusion of all costs, the relative value is composed of two parts. The basic unit of the relative value adjusts for the cost of an average admission within the given diagnostic category. The additional component of the relative value consists of an adjustment to compensate for the costs of exceptionally high cost admissions occurring within the diagnostic category. This factor, when applied to the base rate and the day outlier rate, cause additional payment adjustments to be made to compensate for cost outliers typically found within the diagnostic category. Since all cost is included, the cost outlier threshold is the average cost and is set to pay a cost outlier adjustment for all admissions with a cost that is above the average. The amount of payment adjustment to the operating rate increases as the cost of an admission increases above the average cost.~~

~~**Seven-county metropolitan area hospital.** "Seven-county metropolitan area hospital" means a Minnesota hospital located in one of the following counties: Anoka, Carver, Dakota, Hennepin, Ramsey , Scott, or Washington.~~

~~**Transfer.** "Transfer" means the movement of a recipient after admission from one hospital directly to another hospital with a different provider number or to or from a rehabilitation distinct part.~~

~~**Trim point.** "Trim point" means that number of inpatient days beyond which an admission is a day outlier.~~

~~SECTION 3.0 ESTABLISHMENT OF BASE YEARS~~

~~A. The base year for the 1993 rate year shall be each Minnesota and local trade area hospital's most recent Medicare cost reporting period ending prior to September 1, 1988. If that cost reporting period is less than 12 months, it must be supplemented by information from the prior cost reporting period so that the base year is 12 months except for hospitals that closed during the base year.~~

~~B. The base year data will be moved forward three years beginning with the 1995 rate year. The base year data will be moved forward every two years after 1995, except for 1997 and 2005, 2009 or every one year if notice is provided at least six months prior to the rate year by the Department. For the first three months of the January 1, 2011 rebased rate year, rates shall be rebased at 74.25 percent of the full value of the rebasing percentage change. From April 1, 2011 to March 31, 2012, rates shall be rebased at 39.2 percent of the full value of the rebasing percentage change. Effective April 1, 2012, rates shall be rebased at full value. For long-term care hospitals that open after April 1, 1995, the base year is the year for which the hospital first filed a Medicare cost report. That base year will remain until it falls within the same period as other hospitals.~~

~~**SECTION 4.0 DETERMINATION OF RELATIVE VALUES OF THE DIAGNOSTIC CATEGORIES**~~

~~**4.01 Determination of relative values.** The Department determines the relative values of the diagnostic categories as follows:~~

~~A. Select Medical Assistance claims for Minnesota and local trade area hospitals with admission dates from each hospital's base year.~~

~~B. Exclude the claims and charges in subitems (1) to (7):~~

~~(1) Medicare crossover claims;~~

~~(2) claims paid on a transfer rate per day according to Section 10.03;~~

~~(3) inpatient hospital services for which Medical Assistance payment was not made;~~

~~(4) inpatient hospital claims paid to a long-term care hospital;~~

~~(5) inpatient hospital services not covered by the Medical Assistance program on October 1 prior to a rebased rate year;~~

~~(6) inpatient hospital charges for noncovered days calculated as the ratio of noncovered days to total days multiplied by charges; and~~

~~(7) inpatient hospital services paid under Section 15.11.~~

~~C. Combine claims into the admission that generated the claim according to readmissions at Section 12.2.~~

~~D. Determine operating costs for each hospital admission using each hospital's base year data according to subitems (1) to (4).~~

~~(1) Determine the operating cost of accommodation services by multiplying the number of accommodation service inpatient days by that accommodation service operating cost per diem and add the products of all accommodation services.~~

~~(2) Determine the operating cost of each ancillary service by multiplying the ancillary charges by that ancillary operating cost-to-charge ratio and add the products of all ancillary services. An ancillary operating cost-to-charge ratio will be adjusted for certified registered nurse anesthetist costs and charges if the hospital determines that certified registered nurse anesthetist services will be paid separately.~~

~~(3) Determine the operating cost of services rendered by interns and residents not in an approved teaching program by multiplying the number of accommodation service inpatient days in subitem (1) by that teaching program accommodation service per diem and add the products of all teaching program accommodation services.~~

~~(4) Add subitems (1) to (3).~~

~~E. Assign each admission and operating cost identified in item D, subitem (45), to the appropriate diagnostic category in routine hospital services, or the rehabilitation distinct part specialty group.~~

~~F. Determine the mean cost per admission within routine hospital services and the rehabilitation distinct part specialty group for routine hospital services and rehabilitation distinct part specialty group admissions identified in item E by dividing the sum of the operating costs by the total number of admissions.~~

~~G. Determine the mean cost per admission for each diagnostic category identified in item E for routine hospital services and the rehabilitation distinct part specialty group by dividing the sum of the operating costs in each diagnostic category by the total number of admissions in each diagnostic category.~~

~~H. Determine the relative value for each diagnostic category by dividing item G by the corresponding result of item F for routine hospital services and the rehabilitation distinct part specialty group and round the quotient to five decimal places.~~

~~I. Determine the mean length of stay for each diagnostic category identified in item E for routine hospital services and the rehabilitation distinct part by dividing the total number of inpatient service days in each diagnostic category by the total number of admissions in that diagnostic category and round the quotient to two decimal places.~~

~~J. Determine the day outlier trim point for each diagnostic category for routine hospital services and the rehabilitation distinct part specialty group and round to whole days.~~

~~SECTION 5.0 DETERMINATION OF ADJUSTED BASE YEAR OPERATING COST PER ADMISSION AND PER DAY OUTLIER~~

~~**5.01 Allowable base year operating cost per admission for Minnesota and local trade area hospitals.** The Department determines the allowable base year operating cost per admission for routine hospital services and the rehabilitation distinct part specialty group for each hospital according to items A to D.~~

~~A. Determine and classify the operating cost for each admission according to Section 4.01, items A to E.~~

~~B. Determine the operating costs for day outliers for each admission in item A that is recognized in outlier payments. For each base year admission that is a day outlier, cut the operating cost of that admission at the trim point by multiplying the operating cost of that admission by the ratio of the admission's days of inpatient hospital services in excess of the trim point, divided by the admission's length of stay, and then multiply the cut operating cost by each hospital's elected outlier percentage or 70 percent if an election is not made. When burn diagnostic categories are used, the department shall substitute 90 percent for the 70 percent or elected percentage.~~

~~C. For each admission, subtract item B from item A, and for each hospital, add the results within routine hospital services and the rehabilitation distinct part specialty group, and divide this amount by the number of admissions within routine hospital services and the rehabilitation distinct part specialty group.~~

~~D. Adjust item C for case mix according to subitems (1) to (4).~~

~~(1) Multiply the hospital's number of admissions for routine hospital services and the rehabilitation distinct part specialty group within each diagnostic category by the relative value of that diagnostic category.~~

~~(2) Add together each of the products determined in subitem (1).~~

~~(3) Divide the total from subitem (2) by the number of hospital admissions and round that quotient to five decimal places.~~

~~(4) Divide the cost per admission as determined in item C by the quotient calculated in subitem (3) and round that amount to whole dollars.~~

~~**5.02 Allowable base year operating cost per day outlier for Minnesota and local trade area hospitals.** The Department determines the allowable base year operating cost per day outlier for routine hospital services and the rehabilitation distinct part specialty group for each hospital according to items A and B.~~

~~A. To determine the allowable operating cost per day that is recognized in outlier payments, add the amounts calculated in Section 5.01, item B and divide the total by the total number of days of inpatient hospital services in excess of the trim point.~~

~~B. Adjust item A for case mix according to subitems (1) to (4).~~

~~(1) Multiply the hospital's number of outlier days for routine hospital services and the rehabilitation distinct part specialty group within each diagnostic category by the relative value of that diagnostic category.~~

~~(2) Add the products determined in subitem (1).~~

~~(3) Divide the total from subitem (2) by the number of hospital outlier days.~~

~~(4) Divide the cost per day outlier as determined in item A by the quotient calculated in subitem (3) and round that amount to whole dollars.~~

~~**5.03 Out-of-area hospitals.** The Department determines the allowable base year operating cost per admission and per day outlier for routine hospital services according to items A to C.~~

~~A. Multiply each allowable base year operating cost per admission and per day outlier for each Minnesota and local trade area hospital determined in Sections 5.01 and 5.02 by the number of corresponding admissions or outlier days in that hospital's base year.~~

~~B. Add the products calculated in item A.~~

~~C. Divide the total from item B by the total admissions or outlier days for all the hospitals and round that amount to whole dollars.~~

~~**5.04 Minnesota MSA and local trade area hospitals that do not have five or more Medical Assistance admissions or five or more day outlier Medical Assistance admissions in the base year and low volume local trade area hospitals.** The Department determines the allowable base year operating cost per admission or per day outlier for routine hospital services according to items A to C.~~

~~A. Multiply each allowable base year cost per admission and per day outlier for each Minnesota MSA and local trade area hospital determined in Sections 5.01 and 5.02 by the number of corresponding admissions or outlier days in that hospital's base year.~~

~~B. Add the products calculated in item A.~~

~~C. Divide the total from item B by the total admissions or outlier days for all Minnesota MSA and local trade area hospitals and round that amount to whole dollars.~~

~~**5.05 Non-MSA hospitals that do not have five or more Medical Assistance admissions or five or more day outlier Medical Assistance admissions in the base year.** The Department determines the allowable base year operating cost per admission or per day outlier for routine hospital services for non-MSA hospitals by substituting non-MSA hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under Section 5.04.~~

~~**5.06 Minnesota and local trade area hospitals that do not have five or more Medical Assistance (including General Assistance Medical Care, a State-funded program) rehabilitation distinct part specialty group admissions or five or more day outlier Medical**~~

~~**Assistance rehabilitation distinct part specialty group admissions in the base year.** The Department determines the allowable base year operating cost per admission or per day outlier for the rehabilitation distinct part specialty group for Minnesota and local trade area hospitals by substituting Minnesota and local trade area hospital terms and data for the metropolitan statistical area hospital terms and data under Section 5.04.~~

~~**5.07 Non-seven-county metropolitan area hospitals.** The Department determines the non-seven-county metropolitan area hospital allowable base year operating cost per admission or per day outlier, for routine hospital services and the rehabilitation distinct part specialty group under Section 15.10, by substituting seven-county metropolitan area hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under Section 5.04.~~

~~**5.08 Limitation on separate payment.** Out-of-area hospitals that have a rate established under Section 5.03 may not have certified registered nurse anesthetists services paid separately from this Attachment.~~

~~SECTION 6.0 DETERMINATION OF ALLOWABLE BASE YEAR OPERATING COST PER DAY~~

~~**6.04 Long-term care hospital.**~~

~~The Department determines the base year operating cost per day for long-term care hospitals for the rate year according to items A and B.~~

~~A. Determine the operating cost per day according to Section 4.01, items A to D, except that claims excluded in Section 4.01, item B, subitems (2) and (4), will be included.~~

~~B. Divide the total base year operating costs for all admissions in item A by the total corresponding inpatient hospital days for all admissions and round that amount to whole dollars.~~

~~**6.05 Long-term care hospitals that do not have five or more Medical Assistance (including General Assistance Medical Care, a State-funded program) admissions in the base year.** The Department determines the operating cost per day according to items A to C.~~

~~A. Multiply each operating cost per day for each long-term care hospital as determined in Section 6.04, item B, by the number of corresponding days in that hospital's base year.~~

~~B. Add the products in item A.~~

~~C. Divide the total of item B by the total days for all long-term care hospitals and round that amount to whole dollars.~~

~~**SECTION 8.0 DETERMINATION OF PROPERTY COST PER ADMISSION**~~

~~**8.01 Minnesota and local trade area hospitals.** The Department determines the property cost per admission for each Minnesota and local trade area hospital according to items A to D.~~

~~A. Determine the property cost for each admission in Section 4.01, item C, using each hospital's base year data according to subitems (1) to (4).~~

~~(1) Multiply the number of accommodation service inpatient days by that accommodation service property per diem and add the products.~~

~~(2) Multiply each ancillary charge by that ancillary property cost to charge ratio and add the products.~~

~~(3) Add subitems (1) and (2).~~

~~(4) Add the results of subitem (3) for all admissions for each hospital.~~

~~B. Determine the property cost for each hospital admission in Section 4.01, item C, using each hospital's base year data and recent year Medicare cost report data that was submitted by the October 1 prior to a rebased rate year according to subitems (1) to (4).~~

~~(1) Multiply the base year number of accommodation service inpatient days by that same recent year accommodation service property per diem and add the products.~~

~~(2) Multiply each base year ancillary charge by that annualized recent year property cost to base year charge ratio and add the products.~~

~~(3) Add subitems (1) and (2).~~

~~(4) Add the totals of subitem (3) for all admissions for each hospital.~~

~~C. Determine the change in the property cost according to subitems (1) to (3).~~

~~(1) Subtract item A, subitem (4) from item B, subitem (4), and, if positive, divide the result by item A, subitem (4).~~

~~(2) Multiply the quotient of subitem (1) by 0.85.~~

~~(3) Add one to the result of subitem (2) and round to two decimal places.~~

~~D. Determine the property cost per admission for routine hospital services and the rehabilitation~~

~~distinct part specialty group according to subitems (1) to (3).~~

~~(1) Assign each admission and property cost in item A, subitem (3) to routine hospital services or rehabilitation distinct part specialty group.~~

~~(2) Multiply the cost of each admission in subitem (1) by the factor in item C, subitem (3).~~

~~(3) Add the products within routine hospital services and the rehabilitation distinct part specialty group in subitem (2), divide the total by the number of corresponding admissions, and round the resulting amount to whole dollars.~~

~~**8.02 Out-of-area hospitals.** The Department determines the property cost per admission for routine hospital services according to items A to C.~~

~~A. Multiply each property cost per admission for each Minnesota and local trade area hospital determined in Section 8.01, item D, subitem (3), by the number of corresponding admissions in that hospital's base year.~~

~~B. Add the products in item A.~~

~~C. Divide the total from B by the total admissions for all the hospitals and round the resulting amount to whole dollars.~~

~~**8.03 Minnesota MSA and local trade area hospitals that do not have five or more Medical Assistance admissions in the base year and low volume local trade area hospitals.** The Department determines the property cost per admission for routine hospital services according to items A to C.~~

~~A. Multiply each property cost per admission for each Minnesota MSA and local trade area hospital determined in Section 8.01, item D, subitem (3), by the number of corresponding admissions in the hospital's base year.~~

~~B. Add the products in item A.~~

~~C. Divide the total of item B by the total admissions for all Minnesota MSA hospitals and local trade area hospitals and round the resulting amount to whole dollars.~~

~~**8.04 Non-MSA hospitals that do not have five or more Medical Assistance admissions in the base year.** The Department determines the property cost per admission for routine hospital services for non-MSA hospitals that do not have five or more Medical Assistance admissions in the base year by substituting non-MSA area hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under Section 8.03.~~

8.05 Minnesota and local trade area hospitals that do not have five or more Medical Assistance (including General Assistance Medical Care, a State-funded program) rehabilitation distinct part specialty group admissions in the base year. The Department determines the property cost per admission for the rehabilitation distinct part specialty group for Minnesota and local trade area hospitals that do not have five or more Medical Assistance admissions in the base year substituting Minnesota and local trade area hospital terms and data for the Minnesota MSA and local trade area hospital terms and data under Section 8.03.

8.06 Non-seven county metropolitan area hospitals. The Department determines the non-seven county metropolitan area hospital property cost per admission for routine hospital services and the rehabilitation distinct part specialty group under Section 15.10 by substituting seven-county metropolitan area hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under Section 8.03.

SECTION 9.0 DETERMINATION OF PROPERTY COST PER DAY

9.02 Long-term care hospitals.

A. For long-term care hospitals, the Department determines the property cost per day according to Section 8.01, item D, after substituting the term "day" for "admission," except that claims excluded in Section 4.01, item B, subitems (2) and (4), will be included.

B. For long-term care hospitals that do not have five or more Medical Assistance (including General Assistance Medical Care, a State-funded program) long-term care hospital admissions in the base year, the Department determines a long-term care hospital property cost per day according to Section 8.03, after substituting the term "day" for "admission."

SECTION 10.0 DETERMINATION OF RATE PER ADMISSION AND PER DAY

10.01 Rate per admission. The Department determines the routine hospital services or rehabilitation distinct part specialty group rate per admission for Minnesota and local trade area hospitals as follows:

The payment rates are based on the rates in effect on the date of admission except when the inpatient admission includes both the first day of the rate year and the preceding July 1.

Rate Per Admission = (Allowable base year operating cost per admission multiplied by the relative value of the diagnostic category and multiplied by the disproportionate population adjustment) plus the property cost per admission).

10.02 Rate per day outlier. The day outlier rate is in addition to the rate per admission and will

~~be determined for routine hospital services or the rehabilitation distinct part specialty group as follows:~~

~~A. The rate per day for day outliers is determined as follows:~~

~~Outlier Rate Per Day = Allowable base year operating cost per day outlier multiplied by the relative value of the diagnostic category and multiplied by the disproportionate population adjustment~~

~~B. The days of outlier status begin after the trim point for the appropriate diagnostic category and continue for the number of days a patient receives covered inpatient hospital services, excluding days paid under Section 15.11.~~

~~**10.03 Transfer rate.** Except for admissions subject to Section 10.04, a transfer rate per day for both the hospital that transfers a patient and the hospital that admits the patient who is transferred will be determined as follows:~~

~~Transfer Rate Per Day = (The rate per admission in item A, below, divided by the arithmetic mean length of stay of the diagnostic category)~~

~~A. A hospital will not receive a transfer payment that exceeds the hospital's applicable rate per admission unless that admission is a day outlier.~~

~~B. Except as applicable under Section 12.2, rehabilitation hospitals and rehabilitation distinct parts are exempt from a transfer payment.~~

~~C. An admission that directly precedes an admission to a non-state operated hospital that provides inpatient hospital psychiatric services pursuant to Section 15.07 that is paid according to a contracted rate per day with the Department is exempt from a transfer payment.~~

~~**10.04 Rate per day.**~~

~~A. Admissions that are classified to a diagnostic category of mental health or chemical dependency will be paid according to Section 10.03, except the per day payment is multiplied by a factor of two, provided that the per day payment does not exceed the rate per admission payment under section 10.0.~~

~~B. Admissions with an eligibility date after the date of admission will be paid according to section 10.03.~~

~~C. Admissions or transfers to a long-term care hospital for the rate year will have rates determined according to Section 10.01 after substituting the word "day" for "admission," without regard to relative values.~~

~~**SECTION 12.0 PAYMENT PROCEDURES**~~

~~**12.1 Submittal of claims.** Hospital billings under the Medical Assistance program cannot be submitted until the recipient is discharged. However, the Department establishes monthly interim payments for hospitals that have recipient lengths of stay over 30 days regardless of the diagnostic category.~~

~~**12.2 Payment for readmissions.** An admission and readmission to the same or a different hospital within 15 days, not including the day of admission and the day of discharge, is eligible for payment according to criteria that determines whether the admission and readmission are paid as one admission, two admissions or as transfers. (Outlier payments are paid when applicable.)~~

~~A. An admission and readmission are paid as two admissions when the recipient's discharge from the first admission and subsequent readmission are medically appropriate according to prevailing medical standards, practice and usage. An admission and readmission are also paid as two admissions when the reason for the readmission is the result of:~~

~~(1) A recipient leaving the hospital of the first admission against medical advice;~~

~~(2) A recipient being noncompliant with medical advice that is documented in the recipient's medical record as being given to the recipient; or~~

~~(3) A recipient having a new episode of an illness or condition.~~

~~B. An admission and readmission are paid as a combined admission if they occur at the same hospital, or as transfer payments if they occur at different hospitals, when a recipient is discharged from the first admission without receiving medically necessary treatment because of:~~

~~(1) Hospital or physician scheduling conflict;~~

~~(2) Hospital or physician preference other than medical necessity;~~

~~(3) Patient preference; or~~

~~(4) Referral.~~

~~C. When a readmission occurs as a result of an inappropriate discharge from the first admission, the first admission will be denied payment and the readmission will be considered a separate admission.~~

~~**12.3 Non-payment for hospital-acquired conditions.** Effective for admissions on or after July 1, 2009, no payment will be made for the care, additional treatment or procedures, readmission~~

~~to the hospital after discharge, increased length of stay, change to a higher diagnostic category, or transfer to another hospital when the charges are attributable to a hospital-acquired condition. In the event of a transfer to another hospital, the hospital where the hospital-acquired condition was acquired is responsible for any cost incurred at the hospital to which the patient with the hospital-acquired condition is transferred.~~

~~**12.4 Limit on payment rate for certain deliveries.** Effective for admissions on or after October 1, 2009, a hospital's payment rate for the DRGs listed below shall be no greater than $3,528, exclusive of the adjustments under section 13.0.~~

~~(1) cesarean section without complicating diagnosis 371~~
~~(2) vaginal delivery with complicating diagnosis 372~~
~~(3) vaginal delivery without complicating diagnosis or operating room procedures 373~~

~~SECTION 13.0 DISPROPORTIONATE POPULATION ADJUSTMENT~~

~~The disproportionate population adjustment (DPA) is calculated as the difference between each hospital's Medical Assistance inpatient utilization rate (Medical Assistance days/total days) and the statewide average MA utilization rate plus one standard deviation. Any positive difference is multiplied by the operating part of each hospital's rate only and added to the payment.~~

~~SECTION 14.0 APPEALS~~

~~A hospital may appeal a decision arising from the application of standards or methods of the payment system. An appeal can result in a change to the hospital's payment rate or payments. Both overpayments and underpayments that are discovered as a result of the submission of appeals will be implemented. Regardless of any appeal outcome, relative values shall not be recalculated.~~

~~The appeal will be heard by an administrative law judge according to Minnesota Statutes, chapter 14, or upon agreement by both parties, according to a modified appeals procedure established by the Department and the Office of Administrative Hearings. In any proceeding, the appealing party must demonstrate by a preponderance of the evidence that the Department's determination is incorrect or not according to law.~~

~~A. To appeal a payment rate or payment determination or a determination made from base year information, the hospital must file a written appeal request to the Department within 60 days of the date the payment rate determination was mailed to the hospital. The appeal request shall specify:~~

~~(1) The disputed items.~~

~~(2) The authority in federal or state statute or rule upon which the hospital relies for each disputed item.~~

~~(3) The name and address of the person to contact regarding the appeal.~~

~~B. To appeal a payment rate or payment change that results from a difference in case mix between the base year and the rate year, the procedures and requirements listed above apply. However, the appeal must be filed with the Department or postmarked within 120 days after the end of the rate year. A case mix appeal must apply to the cost of services to all Medical Assistance patients who received inpatient services from the hospital for which the hospital received Medical Assistance payment, excluding Medicare crossovers. The appeal is effective for the entire rate year. A case mix appeal excludes Medical Assistance admissions that have a relative value of zero for its DRG.~~

~~For a case mix appeal filed after July 1, 1997, the combined difference in case mix for Medical Assistance and General Assistance Medical Care, a State-funded program, must exceed five percent. For this paragraph, "hospital" means a facility holding the provider number as an inpatient service facility.~~

~~C. To appeal a payment rate or payment change that results from Medicare adjustments of base year information, the 60-day appeal period begins on the mailing date of the notice by the Medicare program or the date the Medical Assistance payment rate determination notice is mailed, whichever is later.~~

~~D. As part of the appeals process, hospitals are allowed to seek changes that result from differences in the type of services provided or patient acuity from the base year. This is necessary because of the time lag between the base year and the rate year. These case mix appeals are calculated after the rate year has finished. However, in a few situations such as the creation of a new program, it is prospectively evident that a case mix appeal will be successful. Therefore, in these cases, an agreement is drafted mandating a case mix appeal calculation at the end of the year and estimated payments are made on an interim basis.~~

~~SECTION 15.0 OTHER PAYMENT FACTORS~~

~~**15.06 Out of state negotiation.** Out of area payments will be established based on a negotiated rate if a hospital shows that the automatic payment of the out of area hospital rate per admission is below the hospital's allowable cost of the services. A rate is not negotiated until the claim is received and allowable costs are determined. Payments, including third party liability, may not exceed the charges on a claim specific basis for inpatient hospital services that are covered by Medical Assistance.~~

~~**15.10 Non-seven-county metropolitan area hospital payment adjustment.** For a Minnesota hospital located outside of the seven-county metropolitan area, effective for admissions occurring on or after July 1, 2001 for the DRGs listed below, if 90 percent of the seven-county metropolitan area hospital payment is greater than the hospital's payment, exclusive of Sections 13.01 to 13.05 and 15.04, then payment is made at 90 percent of the seven-county metropolitan area hospital payment, inclusive of the hospital's adjustment under Sections 13.01 to 13.05 and 15.04.~~

~~(1) cesarean section with complicating diagnosis 370~~
~~(2) cesarean section without complicating diagnosis 371~~
~~(3) vaginal delivery with complicating diagnosis 372~~
~~(4) vaginal delivery without complicating diagnosis or operating room procedures 373~~
~~(5) extreme immaturity 386~~
~~(6) prematurity without major problems 388~~
~~(7) full term neonates with other problems 390~~
~~(8) normal newborns 391~~
~~(9) neonates, died on birth date 385~~
~~(10) acute adjustment reaction and psychosocial dysfunction 425~~
~~(11) psychosis 430~~
~~(12) childhood mental disorders 431~~
~~(13) appendectomy 164-167~~

~~**Section 15.12 Reduction.** For admissions on or after July 1, 2002, the total payment, before third-party liability and spenddown, is reduced by .5 percent.~~

~~**Section 15.13 Reduction.** In addition to the reduction in Section 15.12, for admissions on or after March 1, 2003, except for psychiatric diagnostic categories, the total payment, before third-party liability and spenddown, is reduced by five percent. The payment is further reduced by 5 percent effective July 1, 2003 for the same categories.~~

~~**Section 15.14 Increase.** Effective with admissions on or after January 1, 2004, the total payment, after third-party liability and spenddown, and Sections 15.12, 15.13, sections 15.17, 15.18, and 15.19 when applicable, and sections 15.21, 15.22 and 15.23 is increased by two percent for Minnesota hospitals.~~

~~**Section 15.17**~~

~~**Section 15.18 Reduction.** In addition to the reductions in Sections 15.12 and 15.13, effective with admissions on or after July 1, 2009 through June 30, 2010, except for psychiatric diagnostic categories, the total payment, after third-party liability and spenddown, is reduced by 1.9 percent.~~

~~**Section 15.19 Reduction.** In addition to the reductions in Sections 15.12, and 15.13, effective with admissions on or after July 1, 2010, except for psychiatric diagnostic categories, the total payment, after third-party liability and spenddown, is reduced by 1.79 percent.~~

~~**Section 15.21 Reduction** In addition to the reduction in Section 15.12, 15.13, and 15.18 and 15.19 when applicable, for admissions on or after July 1, 2009, the total payment, after third-party liability and spenddown, is reduced by one percent.~~

~~**Section 15.22 Hearing detection fee increase.** Effective for admissions occurring on or after July 1, 2010, payment rates shall be adjusted to include the increase to the fee that is effective on July 1, 2010, for the early hearing detection and intervention program recipients under Minnesota statutes §141.125, subdivision 1, that is paid by the hospital for Medical Assistance recipients. This payment increase shall be in effect until the increase is fully recognized within the base year cost.~~

~~**Section 15.23 Reduction** Effective for admissions occurring April 1, 2010 through May 31, 2010 in addition to the reduction in sections 15.12, 15.13, and 15.18 and 15.21, payments are reduced to 37~~ percent of the rates otherwise calculated under this rate setting methodology.

~~Identification of Eligible Costs for Reimbursement through Disproportionate Population Adjustments (DPA also known as DSH) Payments~~

~~The Minnesota Department of Human Services will determine fee-for-service and managed care Medical Assistance and uncompensated care costs for hospitals based on the protocol outlined below.~~

~~Interim Hospital Payment Related to Medical Assistance Costs (Medicaid Shortfall)~~

~~The purpose of the interim Medical Assistance inpatient and outpatient hospital DPA payment is to establish the Medical Assistance inpatient and outpatient hospital eligible costs for the purpose of using a portion of those costs to make a DSH payment in a state fiscal year. The source documents for hospital Medical Assistance fee-for-service days and charge data is the Department's MMIS claim system. The source document for hospital Medical Assistance managed care days and charge data is the hospital's managed care day and charge file as verified by the Department. The hospital will submit to the Department, a file containing patient demographic information, day and charge data by cost center, and total payment data (including co-insurance) for each managed care inpatient and outpatient hospital service during the cost reporting period. The Department will match the patient demographic (name, DOB, SSN, recipient ID) and date of service data in the file received from the hospital to the information in the Department's Medical Assistance eligibility system. The Department will modify the hospital file by deleting any data that is not associated with Medical Assistance and return the modified file to the hospital for inclusion in the cost report.~~

~~The source document for identifying eligible fee-for-service and managed care costs is a hospital's most recent CMS 2552-96 cost report as filed with the Medicare fiscal intermediary. The costs from the CMS 2552-96 are those that are allowable under Medicare cost principles and determined using the Title XIX format. On the CMS 2552-96, total allowable costs for each cost center are from Worksheet B, Part I, column 25 (instead of 27), which includes interns and residents costs since such costs are not separately reimbursed for direct graduate medical education via a per resident amount methodology. These costs are included in the Worksheet C and D series in the Title XIX format. The Medical Assistance days and charge data are for inpatient and outpatient hospital services and exclude non-hospital services including, but not limited to professional services, and non-hospital component services including but not limited to hospital-based nursing and rural health clinic facilities, ambulance services, and physician professional services. An interim annual payment amount will be determined for each state fiscal year.~~

~~The Department will use the protocol outlined below to determine the interim payment for the hospital's uncompensated care costs for treating Medical Assistance fee-for-service and managed care patients:~~

1. Medical Assistance costs for inpatient ancillary services are calculated by multiplying the total Medical Assistance inpatient ancillary charges applicable to each ancillary service cost center by that ancillary service cost center's ratio of costs to charges (RCCs) from Worksheet D-4, column 1, lines 37 to 62. Total inpatient ancillary service cost is reported on Worksheet D-4, column 3, line 101.

2. Medical Assistance costs for outpatient ancillary services are calculated by multiplying the total Medical Assistance outpatient charges applicable to each ancillary service cost center by that ancillary service cost center's RCCs from Worksheet D, Part V, column 1, lines 37 to 62. Total outpatient ancillary service cost is reported on Worksheet D, Part V, column 9, line 101 and Worksheet E-3, Part III, column 1, line 2.

3. Medical Assistance costs for inpatient routine services are calculated by multiplying the total Medical Assistance inpatient days applicable to each routine service cost center by that routine service cost center's average per diem cost from Worksheet D-1, Part II, column 1, line 38 and column 3, lines 42 to 47.03.

4. Medical Assistance costs for inpatient routine and ancillary services are reported on Worksheet D-1, Part II, column 1, line 49 and Worksheet E-3, Part III, column 1, line 1.

5. The total cost for Medical Assistance services is the sum of items 4 and 2 and reported on Worksheet E-3, Part III, column 1, line 6.

6. Hospital payments for Medical Assistance services for coinsurance, recipient resources, and third party liability are reported on Worksheet E-3, Part III, column 1, line 36.

7. Hospital payments for Medical Assistance services, excluding DPA and supplemental payments, are reported on Worksheet E-3, Part III, column 1, line 57.

8. The interim payment before application of the supplemental payments on Worksheet E-3, Part III, column 1, line 58 is item 5 less items 6 and 7.

9. The Department will ensure that the amounts in item 8 are reduced by the total amount hospital's supplemental Medical Assistance payments.

10. The Department will verify that the hospital has used the Medical Assistance data generated from the MMIS claims system, the managed care day encounter file as verified by the Department using the patient demographic data match, and the most recent as filed CMS 2552-96 report.

11. The hospital will certify the CMS 2552-96, Title XIX format. This certification will be completed prior to each claim.

~~**Reconciliation of Interim Hospital Payment Related to Medical Assistance Costs**~~

~~Each non-state, government-owned hospital's interim payment will be subsequently reconciled by the Department based on the hospital's two CMS-2552-96 cost reports that correspond to the state fiscal year in which the interim payment was made as cost reports are filed with the Medicare fiscal intermediary and again as the cost reports are finalized by the Medicare fiscal intermediary. If at the end of the interim or final reconciliation process it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government.~~

~~1. The interim and final reconciliation processes will use the same computation methodology as described for the interim DPA payment except that the hospital Medical Assistance days, charge and payment data from the MMIS claim systems and the managed care encounter file as verified by the Department will be updated, and the CMS-2552-96 cost reports will correspond to the state fiscal year in which the interim payment was made. Revenue offset data will also be updated and verified.~~

~~2. Any differences between the interim payment amount and the interim and final reconciled payment amounts will be made as a prior period adjustment on the CMS-64.~~

~~**Interim Hospital Payment Related to Costs Incurred Providing Services to Uninsured Patients (Uncompensated Care)**~~

~~The purpose of the interim uninsured inpatient and outpatient hospital DPA payment is to establish the uninsured inpatient and outpatient hospital DSH eligible costs for the purpose of using a portion of those costs to make a DSH payment in a state fiscal year. The Department will collect from a non-state, government-owned hospital its cost center specific hospital days and charge data for services it has provided to uninsured patients including payments the hospital has received from or on behalf of those uninsured patients. The uninsured are individuals who have no health insurance or other source of third party coverage. Uninsured days, charge and payment data will be entered into the CMS-2252-96 to determine the DSH eligible costs related to services provided to uninsured patients. The source documents for identifying eligible costs are a hospital's most recent CMS 2552-96 cost report as filed with the Medicare fiscal intermediary. The costs from the CMS-2552-96 are those that are allowable under Medicare cost principles. As discussed in the Interim Medical Assistance Payment section, total allowable costs for each cost center are from Worksheet B, Part I, column 25 (instead of 27). These costs will be included in the Worksheet C and D series. The uninsured days and charge data are for inpatient and outpatient hospital services and exclude non-hospital services including, but not limited to professional services, and non hospital component services including but not limited to hospital-based nursing and rural health clinic facilities, ambulance services, and physician professional services. The CEO and CFO of each hospital, or a designee, will sign and certify to the accuracy of the information on the cost report.~~

~~The Department will use the protocol outlined below to determine interim payment for a hospital:~~

1. Uninsured costs for inpatient ancillary services are calculated by multiplying the total uninsured inpatient ancillary charges applicable to each ancillary service cost center by that ancillary service cost center's ratio of costs to charges (RCCs) from Worksheet D-4, column 1, lines 37 to 62. Total inpatient ancillary service cost is reported on Worksheet D-4, column 3, line 101.

2. Uninsured costs for outpatient ancillary services are calculated by multiplying the total uninsured outpatient charges applicable to each ancillary service cost center by that ancillary service cost center's RCCs from Worksheet D, Part V, column 1, lines 37 to 62. Total outpatient ancillary service cost is reported on Worksheet D, Part V, column 9, line 101 and Worksheet E-3, Part III, column 1, line 2.

3. Uninsured costs for inpatient routine services are calculated by multiplying the total uninsured inpatient days applicable to each routine service cost center by that routine service cost center's average per diem cost from Worksheet D-1, Part II, line 38 and column 3, lines 42 to 47.03.

4. Uninsured costs for inpatient routine and ancillary services are reported on Worksheet D-1, Part II, column 1, line 49 and Worksheet E-3, Part III, column 1, line 1.

5. The total cost for uninsured services is the sum of items 4 and 2 and reported on Worksheet E-3, Part III, column 1, line 6.

6. Hospital payments made by or on behalf of uninsured patients are reported on Worksheet E-3, Part III, column 1, line 57.

7. The interim payment is Worksheet E-3, Part III, column 1, line 58 in item 5 less item 6.

8. The Department will require that the hospital certify the eligible uninsured day, charge and payment used in the CMS-2552-96, Title XIX format. . This certification will be completed prior to each claim.

Reconciliation of Interim Hospital Payment for Uninsured Patients

1. The interim and final reconciliation processes will use the same computation methodology as described in the interim payment process except that the hospital uninsured days, charge and payment data will be updated and drawn from the two audited CMS-2552-96, Title XIX cost reports that correspond to the state fiscal year in which the interim DSH payment was made, as those cost reports are filed with and then finalized by the Medicare fiscal intermediary. Revenue offset data will also be updated and verified.

2. Any difference between the interim payment amount and the interim and final reconciled payment amounts will be made as a prior period adjustment on the CMS-64.

~~months. The Department will ensure that the total costs claimed under this DSH payment provision in a state plan DSH payment year will not exceed the costs justified in the underlying hospital cost reports for the applicable years.~~

~~The Department will also use the interim and final reconciliation process to ensure that the DPA payment claims for FFP do not result in total DSH claims exceeding the Minnesota's overall DSH allotment for the applicable FFY.~~

Supplemental Payment for Medical Education

In addition to Medical Assistance payments included in this Attachment, Medical Assistance provides for an additional annual payment by April 30 of each year for the previous state fiscal year for distribution to Medical Assistance-enrolled eligible teaching hospitals. A single pool of money equal to $7,575,000 is used to make supplemental payments to qualifying providers that include both institutional eligible training sites, and non-institutional eligible training sites described in Attachment 4.19-B Supplement 2. The Medical Assistance payment is increased in an amount equal to:

(1) $7,575,000, multiplied by a proportion equal to the hospital's public program revenue divided by the total amount of public program revenue of all qualifying providers ~~eligible training sites~~. Public program revenue is the sum of a provider's revenue from medical assistance, prepaid medical assistance, and through June 30, 2014, general assistance medical care and prepaid general assistance medical care.

(2) For hospitals with public program revenue equal to or greater than 0.98 percent of the total public program revenue of all qualifying providers ~~eligible training sites~~, payments are increased by 20 percent.

(3) Payments to hospitals ~~training sites~~ with public program revenue less than 0.98 percent of the total public program revenue of all qualifying providers ~~eligible training sites~~ are reduced proportionately to fund the payment increases described in sub-item (2).

Effective July 1, 2015:

(4) Subitems (2) and (3) above no longer apply.

(5) Qualifying providers ~~Training sites~~ with no public program revenue, fewer than .1 FTE eligible trainees, or whose payment under subitem (1) would result in less than $5,000, are not eligible for increased payments.

(6) No qualifying provider shall receive a payment that is in excess of the 95th percentile for payment per FTE across all qualified providers. Excess payments shall be redistributed according to the formula above.

~~For State Fiscal Year 2013 only, the amount available in paragraph (1) above is $7,275,000, and prior to the formula in paragraphs (1) to (4), the annual payment to Gillette Children's Specialty Healthcare is increased by $300,000.~~

Supplemental Payment for Medical Education (cont'd)

Qualifying Provider. "Qualifying provider" means a Medical Assistance enrolled hospital, medical center, clinic, practitioner, or other organization that provides accredited clinical training of: physicians (medical students and residents), doctor of pharmacy practitioners, doctors of chiropractic, dentists, advance practice nurses (clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), ~~and~~ physician assistants, and effective July 1, 2015, dental therapists, advanced dental therapists, psychologists, clinical social workers, community paramedics, and community health workers; and that has successfully applied for this payment, in accordance with Minnesota Statutes § 62J.692.

Methods and Standards for Determining Payment Rates for Services Provided by Psychiatric Residential Treatment Facilities as Described in Item 16 of Attachments 3.1-A and 3.1-B.

Providers of services delivered to a child residing in **psychiatric residential treatment facility (PRTF)** are paid a per diem. The per diem is a statewide rate and informed by annual cost reporting performed by the providers. Providers report costs using a state-developed cost report. The per diem includes costs for the following three components:

1. Allowable direct service expenditures. Direct service expenditures include, costs associated with the program's treatment team (salaries, training and fringe), service-related transportation, and costs for contracted staff participating on the treatment team. This does not include costs associated with services provided under arrangement.

2. Allowable administrative costs. Administrative costs include, but are not limited to, administrative staff costs (salary and fringe), insurance, professional dues, and supplies.

3. Allowable room and board costs. Room and board costs include all costs related to housing the recipient.

Effective for services provided on or after January 1, 2018, through June 30, 2019, the per diem is based on the average estimated costs reported by the providers after eliminating outliers. In subsequent years, the statewide per diem is informed by cost reporting using the actual experience of all providers during the previous calendar year. The Department recalculates the statewide per diem annually and implements the new rate July 1 of each year.

Therapeutic leave days, as described in Attachment 4.19-C, are paid at 75% of the established per diem rate.

Hospital leave days, as described in Attachment 4.19-C, are paid at 50% of the established per diem rate.

Services provided under arrangement to a recipient residing in a PRTF on or after January 1, 2018, will be reimbursed for the particular service as described in Attachment 4.19-B.

Methods and Standards for Determining Payment Rates for Inpatient Hospital Services Provided in Regional Treatment Center (RTCs) Programs for Persons with Mental Illness

1.0 PURPOSE AND SCOPE

This attachment describes the methods and standards for determining payment rates for inpatient hospital services for individuals age 65 and older in institutions for mental diseases and for inpatient psychiatric services for individuals under age 21. This description only applies to services provided in State-owned facilities.

Minnesota has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

2.0 METHODOLOGY

Payment rates are determined annually on a cost-related basis using Medicare principles of cost reimbursement with the following exceptions.

2.1 **Interim Rates** are calculated on a per diem basis for each State fiscal year (July 1 to June 30) for individual treatment programs for mental illness. The sum of anticipated allowable costs is divided by the number of projected patient days. This amount is increased by a disproportionate share hospital (DSH) adjustment. Interim rates are approved for Medicaid by the Medicare intermediary and settlement is reached at the end of the year.

2.2 **Final Rates** are calculated by dividing total allowable costs by in-house patient days. This amount is increased by any DSH.

2.3 **Costs** include: salaries; current expenses (fuel, utilities food, drugs, and other expenses); repairs and betterment; depreciation of buildings and equipment; building bond interest; other capital requirements; and other expenses related to patient care, such as physician and ancillary services, central office support (program supervisory staff), collections administration for RTCs, other indirect costs (Department personnel, medical director, information systems, and program analysis), statewide support costs (central payroll, statewide payroll), and other State agency support to RTCs.

2.4 **Projected Patient Days** are determined from population estimates, based upon actual patient days and trends shown from prior years. Projected patient days are calculated as follows:

A. For each month of the prior fiscal year, divide the number of patient days in the month by the number of calendar days in the month. This represents the average daily census.
B. Sum the average daily census (A) for the 12 months of the prior fiscal year.
C. Divide (B) by 12 months.
D. Multiply (C) by 365 days.

The resultant projected patient days must be reviewed for reasonableness by taking into account any anticipated material changes in operations.

2.5 DSH Payments are provided in compliance with §1923 of the Social Security Act. The obstetric services requirements under §1923 of the Act do not apply to the RTCs because the facilities did not offer nonemergency obstetric services as of December 21, 1987. The facility must have a Medicaid utilization rate of at least one percent. Eligibility for a DSH payment is established under either the Medicaid inpatient utilization rate criteria or the low-income utilization rate criteria under §1923(b), as follows:

2.51 Medicaid Inpatient Utilization Rate If the ratio of the hospital's Medicaid inpatient days to total inpatient days exceeds the mean for all Minnesota Medicaid enrolled hospitals plus one standard deviation of the mean, a facility may be eligible for a DSH payment.

2.52 Low-Income Utilization Rate DSH payment eligibility may also be calculated by determining the ratio of MA revenues (plus any cash subsidies received by the hospital directly from state and local government) to total revenues (plus the cash subsidies amount).

This ratio is added to the ratio of inpatient charity care charges minus the cash subsidies to total charges. Charity care refers to care provided to individuals who have no source of payment, third party or personal resources. If the sum of the two ratios exceeds .25, the hospital is eligible for a DSH payment.

The RTCs are tested under both methods. The DSH adjustment percentage is determined by subtracting .25 from the facility's actual low income utilization rate. This percentage is multiplied by the total rate to establish the DSH payment. The DSH payment for the RTCs is based on the low-income utilization rate method and is limited by the facility-specific limit of §1923(g) of the Act and subject to the institution for mental diseases (IMD) limit of §1923(h) of the Act.

Following is the detailed formula utilized to calculate the DSH percentage. The most recently settled Medicaid cost settlement is the basis for calculating the DSH percentage. Therefore, for interim rates, the DSH percentage calculations are based on the cost settlement from the second previous fiscal year (i.e., fiscal year 1992 interim rate DSH percentage is based on fiscal year 1990 settlement). For final rates, the DSH percentage calculations are based on the cost settlement for the previous fiscal year.

2.53 DSH Percentage

(A) MA MI* Patient Revenue: Most recently settled Medicaid cost settlement plus Medicaid receipts for the same year less the amount of any prior year's Medicaid settlement included in the receipts.

* MI =mentally ill or mental illness

(B) Cash subsidies [B(1)- B(2)]:

Because the State absorbs the costs exceeding receipts, Cash Subsidies equals the Cost of MI Programs (1) less Total MI Collections (2):

(1) Cost of MI Programs: Amounts reported as allowable cost for the prior year's Medicaid cost settlement.

(2) Total MI Collections: Total receipts reported, adjusted for Medicaid cost settlement in the same manner as MA MI Patient Revenue (A).

(C) Federal and State Funds [A +B]

(D) Total Revenue [B(2)]

(E) Cash Subsidies [B]

(F) Total Revenue +Cash Subsidies [D +E]

(G) Ratio of Government Funding: Total [C/F]:

The percent of resources provided by federal and state government to supply services to low income clients.

(H) Cost of Charity Care [B]

(I) Cash Subsidies [B]

(J) Net of Subsidies and Charity [H-I]:

Subtracting the Cost of Charity Care (H) from the amount of Cash Subsidies (I) always equals zero.

(K) Total Charges: Total patient days times the total per diem rate.

(L) Percent of Charges Unreimbursed [J/K]

(M) Government Funding +Uncovered Care [G +L]

(N) DSH Percentage [M - .25]

2.6 Additional DSH Payment For any federal fiscal year in which the State's DSH allotment under §1923(f) of the Act is not otherwise expended, State-operated inpatient hospital DSH payments are increased as follows:

(A) Except as provided in item (B), the amount of the unexpended DSH allotment is prorated among the State-operated inpatient hospitals eligible for a DSH payment under §2.5.

(B) If the DSH payment in item (A) would cause a facility to exceed its facility-specific DSH limit under §1923(g) of the Act, the amount exceeding the limit is prorated among the remaining facilities. This payment formula is applied until any of the following occur:

(1) All of the formerly unexpended DSH allotment is expended.

(2) All of the RTCs have DSH payments that equal their facility-specific DSH limits.

(3) The DSH payments to IMDs exceed the limit established under §1923(h) of the Act.

2.7 Additional Medical Education Payment

Medical Assistance provides for an additional annual payment according to the formula in Supplement 3 of this attachment. ~~for State Fiscal Year 2011 and thereafter, which includes a Department medical education payment made for each fiscal year to a sponsoring institution prior to April 30 of each year for the previous state fiscal year, for distribution to Medical Assistance enrolled teaching hospitals. Effective July 1, 2007, the Medical Assistance payment is increased by an amount equal to:~~

~~(1) $7,575,000 multiplied by a proportion equal to the hospital's public program revenue divided by the total amount of public program revenue of all eligible training sites. Public program revenue is the sum of a provider's revenue from medical assistance, prepaid medical assistance, general assistance medical care and prepaid general assistance medical care.~~

~~(2) For hospitals with public program revenue equal to or greater than 0.98 percent of the total public program revenue of all eligible training sites, payments are increased by 20 percent.~~

~~(3) Payments to training sites with public program revenue less than 0.98 percent of the total public program revenue of all training eligible sites are reduced proportionately to fund the payment increases described in paragraph (B)~~

~~In accordance with Code of Federal Regulations, title 42, section 447.253(b)(2), this payment will not exceed the Medicare upper payment and charge limits as specified in Code of Federal Regulations, title 42, section 447.272.~~

~~In accordance with Code of Federal Regulations, title 42, section 447.253(b)(2), this payment will not exceed the Medicare upper payment and charge limits as specified in Code of Federal Regulations, title 42, section 447.272.~~

Methods and Standards for Determining Payment Rates for Inpatient Hospital Services Provided in the State-owned Minnesota Neurorehabilitation Hospital (MNH)

1.0 PURPOSE AND SCOPE

This attachment describes the methods and standards for determining payment rates for traumatic brain injury services for individuals in the state-owned Minnesota Neurorehabilitation Hospital (MNH), a traumatic brain injury hospital with less than 16 beds.

Minnesota has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

2.0 METHODOLOGY

Payment rates are determined annually on a cost-related basis using Medicare principles of reimbursement as specified in *Provider Reimbursement Manual* - HCFA 15, parts I and II with the following exception that a disproportionate share hospital (DSH) payment adjustment shall be made in accordance with the following:

2.1 Interim Rates are calculated on a per diem basis for each State fiscal year (July 1 to June 30) for individual treatment programs for mental illness. The sum of anticipated allowable costs is divided by a disproportionate share hospital (DSH) adjustment. Interim rates are approved for Medicaid by the Medicare intermediary and settlement is reached at the end of the year.

2.2 Final Rates are calculated by dividing total allowable costs by in-house patient days. This amount is increased by any DSH.

2.3 Costs include: salaries; current expenses (fuel, utilities food, drugs, and other expenses); repairs and betterment; depreciation of buildings and equipment; building bond interest; other capital requirements; and other expenses related to patient care, such as physician and ancillary services central office support (program supervisory staff), collections administration for RTCs, other indirect costs (Department personnel, medical director, information systems, and program analysis), statewide support costs (central payroll, statewide payroll), and other State agency support to RTCs.

2.4 Projected Patient Days are determined from population estimates, based upon actual patient days and trends shown from prior years.

2.5 DSH Payments are provided in compliance with §1923. The obstetric services requirements under §1923 of the Act do not apply to the MNH because the facility did not offer nonemergency obstetric services as of December 21, 1987. The facility must have a Medicaid utilization rate of at least one percent. Eligibility for a DSH payment is established under either the Medicaid inpatient utilization rate criteria or the low-income utilization rate criteria under §1923(b), as follows:

2.51 Medicaid Inpatient Utilization Rate If the ratio of the hospital's Medicaid inpatient days to total inpatient days exceeds the mean for all Minnesota Medicaid enrolled hospitals plus one standard deviation of the mean, a facility may be eligible for a DSH payment.

2.52 Low-Income Utilization Rate DSH payment eligibility may also be calculated by determining the ratio of MA revenues (plus any cash subsidies received by the hospital directly from state and local government) to total revenues (plus the cash subsidies amount).

This ratio is added to the ratio of inpatient charity care charges minus the cash subsidies to total charges. Charity care refers to care provided to individuals who have no source of payment, third party or personal resources. If the sum of the two ratios exceeds .25, the hospital is eligible for a DSH payment.

The MNH is tested under both methods. The Department chooses the low income utilization rate method where the DSH adjustment percentage is determined by subtracting .25 from the facility's actual low income utilization rate. This percentage is multiplied by the total rate to establish the DSH payment. The DSH payment for the MNH is based on the low income utilization rate method and is limited by the facility-specific limit of §1923(g) of the Act and subject to the institution for mental diseases (IMD) limit of §1923(h) of the Act.

The most recently settled Medicaid cost settlement is the basis for calculating the DSH percentage. Therefore, for interim rates, the DSH percentage calculations are based on the cost settlement from the second previous fiscal year (i.e., fiscal year 1990 interim rate DSH percentage is based on fiscal year

1988 settlement). For final rates, the DSH percentage calculations are based on the cost settlement for the previous fiscal year.

2.53 DSH Percentage

(A) MA MI* Patient Revenue: Most recently settled Medicaid cost settlement plus Medicaid receipts for the same year less the amount of any prior year's Medicaid settlement included in the receipts.

(B) Cash subsidies [B(1)- B(2)]:

Because the State absorbs the costs exceeding receipts, Cash Subsidies equals the Cost of MI Programs (1) less Total MI Collections (2):

(1) Cost of MI Programs: Amounts reported as allowable cost for the prior year's Medicaid cost settlement.

(2) Total MI Collections: Total receipts reported, adjusted for Medicaid costs settlement in the same manner as MA MI Patient Revenue (A).

(C) Federal and State Funds [A + B]

(D) Total Revenue [B(2)]

(E) Cash Subsidies [B]

(F) Total Revenue + Cash Subsidies [D + E]

* MI = mentally ill or mental illness

(G) Ratio of Government Funding: Total [C/F]:

The percent of resources provided by federal and state government to supply services to low income clients.

(H) Cost of Charity Care [B]

(I) Cash Subsidies [B]

(J) Net of Subsidies and Charity [H-I]:

Subtracting the Cost of Charity Care (H) from the amount of Cash Subsidies (I) always equals zero.

(K) Total Charges: Total patient days times the total per diem rate.

(L) Percent of Charges Unreimbursed [J/K]

(M) Government Funding + Uncovered Care [G + L]

(N) DSH Percentage [M - .25]

2.6 Additional DSH Payment For any federal fiscal year in which the State's DSH allotment under §1923(f) of the Act is not otherwise expended, state-operated inpatient hospital DSH payments are increased as follows:

(A) Except as provided in item (B), the amount of the unexpended DSH allotment is prorated among the state-operated inpatient hospitals eligible for a DSH payment under §2.5.

(B) If the DSH payment in item (A) would cause a facility to exceed its facility-specific DSH limit under §1923(g) of the Act, the amount exceeding the limit is prorated among the remaining facilities. This payment formula is applied until ~~either~~ any of the following occur:

(1) All of the formerly unexpended DSH allotment is expended~~; or~~ .

(2) All of the state-owned hospitals have DSH payments that equal their facility-specific DSH limits~~, whichever occurs first~~ .

(3) The DSH payments to IMDs exceed the limit established under §1923(h) of the Act.

Methods and Standards for Determining Payment Rates for Inpatient Hospital Services Provided in State-Operated Psychiatric Hospitals with Fewer than 17 Beds

1.0 PURPOSE AND SCOPE

This attachment describes the methods and standards for determining payment rates for inpatient hospital services provided by state-operated psychiatric hospitals with fewer than 17 beds.

Minnesota has a public process in place that complies with the requirements of section 1902(a)(13)(A) of the Social Security Act.

2.0 METHODOLOGY

Payment rates are determined annually on a cost-related basis using Medicare principles of cost reimbursement as specified in the Medicare Provider Reimbursement Manual - Part 1 (CMS Pub. 15-1), except that costs include physician services. Costs for physician services cannot be claimed under any other payment methodologies that may otherwise be applicable.

2.1 Interim Rates are calculated on a per diem basis for each state fiscal year, using total costs for the prior year, multiplied by an inflation factor, and divided by projected patient days for the current year. The inflation factor is the Medicare Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) market basket inflation factor, as published annually in the *Federal Register*.

2.2 Interim Rates shall be determined by dividing projected costs for the first 16 months of operation, by estimated patient days for the first 16 months of operation.

2.3 Final Rates are calculated by dividing total allowable costs by total, actual patient days.

Supplemental Payment for Medical Education

In addition to Medical Assistance payments included in this Attachment, Medical Assistance provides for an additional annual payment by April 30 of each year for the previous state fiscal year for distribution to Medical Assistance-enrolled eligible teaching hospitals. A single pool of money equal to $7,575,000 is used to make supplemental payments to qualifying providers that include both institutional eligible training sites, and non-institutional eligible training sites described in Attachment 4.19-B Supplement 2. The Medical Assistance payment is increased in an amount equal to:

(1) $7,575,000, multiplied by a proportion equal to the hospital's public program revenue divided by the total amount of public program revenue of all qualifying providers ~~eligible training sites~~. Public program revenue is the sum of a provider's revenue from medical assistance, prepaid medical assistance, and through June 30, 2014, general assistance medical care and prepaid general assistance medical care.

(2) For hospitals with public program revenue equal to or greater than 0.98 percent of the total public program revenue of all qualifying providers ~~eligible training sites~~, payments are increased by 20 percent.

(3) Payments to hospitals ~~training sites~~ with public program revenue less than 0.98 percent of the total public program revenue of all qualifying providers ~~eligible training sites~~ are reduced proportionately to fund the payment increases described in sub-item (2).

Effective July 1, 2015:

(4) Subitems (2) and (3) above no longer apply.

(5) Qualifying providers ~~Training sites~~ with no public program revenue, fewer than .1 FTE eligible trainees, or whose payment under subitem (1) would result in less than $5,000, are not eligible for increased payments.

(6) No qualifying provider shall receive a payment that is in excess of the 95th percentile for payment per FTE across all qualified providers. Excess payments shall be redistributed according to the formula above.

~~For State Fiscal Year 2013 only, the amount available in paragraph (1) above is $7,275,000, and prior to the formula in paragraphs (1) to (4), the annual payment to Gillette Children's Specialty Healthcare is increased by $300,000.~~

Supplemental Payment for Medical Education (cont'd)

Qualifying Provider. "Qualifying provider" means a Medical Assistance enrolled hospital, medical center, clinic, practitioner, or other organization that provides accredited clinical training of: physicians (medical students and residents), doctor of pharmacy practitioners, doctors of chiropractic, dentists, advance practice nurses (clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), ~~and~~ physician assistants, and effective July 1, 2015, dental therapists, advanced dental therapists, psychologists, clinical social workers, community paramedics, and community health workers; and that has successfully applied for this payment, in accordance with Minnesota Statutes § 62J.692.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care

~~The following is a description of the policy and methods used in establishing payment rates for each type of care and services included in the State plan.~~

~~Medical Assistance payment for Medicare crossover claims is equal to the Medicare co-insurance and deductible.~~

~~IHS/638 Facilities: Except for child welfare-targeted case management services and relocation service coordination services, services provided by facilities of the Indian Health Service (which include, at the option of a tribe, facilities owned or operated by a tribe or tribal organization, and funded by Title I of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, P.L. 106-260, operating as 638 facilities) are paid at the rates negotiated between the Indian Health Service and the Centers for Medicare & Medicaid Services and published by the Indian Health Service in the Federal Register. Child-welfare targeted case management services are paid in accordance with the methodology in item 19.b., child welfare-targeted case management services. Relocation service coordination services are paid in accordance with the methodology in item 19.c, relocation service coordination services.~~

~~Outpatient services provided by facilities defined in state law as critical access hospitals (and certified as such by the Centers for Medicare & Medicaid Services) are paid on a cost-based payment system based on the cost-finding methods and allowable costs of Medicare.~~

~~Except in the case of critical access hospitals, for obstetric care the base rate is adjusted as follows:~~

- ~~outpatient hospital obstetric care (as defined by the Department) technical component (provided by outpatient hospital facilities) receives a 10% increase over the base rate.~~

- ~~all other obstetric care (as defined by the Department) receives a 26.5% increase over the base rate.~~

~~Pediatric care (as defined by the Department), except for the technical component provided by an outpatient hospital facility, receives a 15% increase over the base rate.~~

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care (continued)

~~Oral language interpreter services, provided by enrolled providers (except inpatient hospitals) to persons with limited English proficiency, are paid the lesser of charges or $12.50 per 15-minute unit of service. Effective July 1, 2009, payment rates for these services rendered on or after July 1, 2009, are reduced by five percent. Effective for these services rendered on or after July 1, 2009, and before July 1, 2010, rates are reduced by an additional one and one half percent. Effective July 1, 2010, payment rates for these services rendered on or after July 1, 2010, are reduced by an additional seven percent.~~

~~Legislation governing maximum payment rates sets the calendar year at 1989, except that: (1) the calendar year for item 7, home health services, is set at 1982, and (2) the calendar year for outpatient mental health services is set at 1999 (payment is 75.6% of the 50th percentile of calendar year 1999 charges). Rates for services provided by community and public health clinics are increased by 20%, except for laboratory services.~~

~~**Rate Decrease Effective July 1, 2002:** Total payment paid to hospitals for outpatient hospital facility services provided on or after July 1, 2002, before third party liability and spenddown, is decreased by .5 percent from current rates.~~

~~**Rate Decrease Effective March 1, 2003:** Total payment paid to hospitals for outpatient hospital facility services provided on or after March 1, 2003 and through June 30, 2003, before third party liability and spenddown, is decreased by 5 percent from current rates.~~

~~**Rate Decrease Effective July 1, 2003:** Total payment paid to hospitals for outpatient hospital facility services provided on or after July 1, 2003, before third party liability and spenddown, is decreased by 5 percent from the rates in effect on February 28, 2003. This decrease does not include services provided by IHS or 638 facilities.~~

~~**Rate Increase Effective January 1, 2004:** Total payment for services provided on or after January 1, 2004 is increased by two percent if services are subject to outpatient hospital, surgical center, or health care provider taxes. The list of affected providers and services is found on page 1c.~~

~~Exceptions to the 50th percentile of the submitted charges occur in the following situations:~~

~~(1) There were less than 5 billings in the calendar year specified in legislation governing maximum payment rates;~~
~~(2) The service was not available in the calendar year specified in legislation governing maximum payment rates;~~
~~(3) The payment amount is the result of a provider appeal.~~

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care (continued)

~~**Rate Decrease Effective July 1, 2008:** Total payment paid to hospitals for outpatient hospital facility services provided on or after July 1, 2008, before third party liability and spenddown, is decreased by 3 percent. This decrease does not include psychiatric diagnostic categories or services provided by IHS or 638 facilities.~~

~~**Rate Decrease Effective January 1, 2009 for certain professional services and eyeglasses:** A $3.00 rate reduction is applicable to the following services provided to recipients for whom a copay had been required prior to January 1, 2009:~~

- ~~Eyeglass services;~~
- ~~Non-preventive services provided by the following:~~
  - ~~Physicians~~
  - ~~Public health nursing~~
  - ~~Optometrists~~
  - ~~Podiatrists~~
  - ~~Chiropractors~~
  - ~~Audiologists~~
  - ~~Opticians~~
  - ~~Nurse practitioners~~
  - ~~Nurse midwives~~
  - ~~Clinical nurse specialists~~
  - ~~Physician assistants~~

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care (continued)

~~(4) The procedure code description has changed since the calendar year specified in the legislation governing maximum payment rates, therefore, the prevailing charge information reflects the same code but a different procedure description;~~
~~(5) The 50th percentile reflects a payment which is inequitable when compared with payment rates for procedures or services which are substantially similar or when compared with payment rates for procedure codes or different levels of complexity in the same or substantially similar category; or~~
~~(6) The procedure code is for an unlisted service.~~

~~In these instances, the following methodology is used to reconstruct a rate comparable to the 50th percentile of charges submitted in the calendar year specified in legislation governing maximum payment rates:~~

~~(1) Refer to information which exists for the first four billings in the calendar year specified in legislation governing maximum payment rates; and/or~~
~~(2) Refer to surrounding and/or comparable procedure codes; and/or~~
~~(3) Refer to the 50th percentile of years subsequent to the calendar year specified in legislation governing maximum payment rates; and "backdown" the amount by applying an appropriate CPI formula. The CPI formula is updated July 1 of each year to incorporate the current year's CPI; and/or~~
~~(4) Refer to relative value indexes; and/or~~
~~(5) Refer to payment information from other third parties, such as Medicare; and/or~~
~~(6) Refer to a previous rate and add the aggregate increase to the previous rate; and/or~~
~~(7) Refer to the submitted charge and "backdown" the charge by the CPI formula. The CPI formula is updated July 1 of each year to incorporate the current year's CPI.~~

~~If a procedure was authorized and approved prior to a reference file rate change, the approved authorized payment rate may be paid rather than the new reference file allowable.~~

~~HCPCS MODIFIERS~~

~~Medical Assistance pays more than the reference file allowable in the following areas:~~

~~20 microsurgery = 35% additional reimbursement.~~

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care (continued)

~~22 unusual procedural services = additional reimbursement based on line description or claim attachment. This modifier specifies a ratio for twin delivery and VBAC delivery. All other services are priced according to the service rendered.~~

~~99 multiple modifier = may be an increase or a decrease to the reference file allowable depending on the modifiers represented within the 99.~~

~~In accordance with Minnesota Statutes, §256B.37, subdivision 5a: No Medical Assistance payment will be made when either covered charges are paid in full by a third party payer or the provider has an agreement with a third party payer to accept payment for less than charges as payment in full.~~

~~Payment for patients that are simultaneously covered by Medical Assistance and a liable third party other than Medicare will be made as the lesser of the following:~~

~~(1) the patient liability according to the provider/third party payer (insurer) agreement;~~

~~(2) covered charges minus the third party payment amount; or~~

~~(3) the Medical Assistance rate minus the third party payment amount.~~

~~IHS/638 FACILITIES:~~

~~An encounter for a 638 or IHS facility means a face-to-face encounter/visit between a recipient eligible for Medical Assistance and any health professional at or through an IHS or 638 service location for the provision of Title XIX covered services in or through an IHS or 638 facility within a 24-hour period ending at midnight. Encounters/visits with more than one health professional and multiple encounters/visits with the same professional, within the same service category, that take place in the same 24-hour period, constitute a single encounter/visit, except when the recipient after the first encounter/visit suffers an illness or injury requiring additional diagnosis or treatment. Service categories for IHS/638 facilities are: ambulance, chemical dependency, dental, home health, medical, mental health, and pharmacy.~~

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care (continued)

~~Total payment for services provided on or after January 1, 2004 is increased by two percent for the following Minnesota providers and services:~~

- ~~outpatient hospital services~~
- ~~x-ray services~~
- ~~EPSDT services, excluding rehabilitative services and services provided to a recipient with severe emotional disturbance residing in a children's residential treatment facility~~
- ~~physicians' services~~
- ~~medical and surgical services furnished by a dentist~~
- ~~podiatrists' services~~
- ~~optometrists' services~~
- ~~chiropractors' services~~
- ~~other practitioners' services: mental health, public health nursing, ambulatory surgical center, certified registered nurse anesthetist, nurse practitioner, case management services provided as a component of receiving clozapine, and clinical nurse specialist services~~
- ~~clinic services~~
- ~~dental services~~
- ~~physical therapy services~~
- ~~occupational therapy services~~
- ~~speech, language, and hearing therapy services~~
- ~~dentures~~
- ~~eyeglasses~~
- ~~diagnostic, screening, and preventive services~~
- ~~rehabilitative services: day treatment for mental illness, services for treating chemical abuse, rehabilitative restorative and specialized maintenance physical therapy, occupational therapy, and speech, language and hearing therapy services, and respiratory therapy services~~
- ~~services for individuals age 65 or older in institutions for mental diseases~~
- ~~inpatient psychiatric facility services for individuals under 22 years of age~~
- ~~nurse midwife services~~
- ~~pregnancy related and post partum services for 60 days after the pregnancy ends~~
- ~~services for any other medical condition that may complicate pregnancy~~
- ~~certified pediatric or family nurse practitioner services~~
- ~~licensed ambulance services, excluding volunteer ambulance services~~
- ~~emergency hospital services~~

1. Inpatient hospital services other than those provided in an institution for mental diseases.

See Attachment 4.19-A.

2.a. Outpatient hospital services (cont).

Payments for outpatient hospital services may not exceed in aggregate the total payments that would have been paid under Medicare.

Outpatient hospital facility services are paid in accordance with the most recent Ambulatory Payment Classification system rates published by the Centers for Medicare & Medicaid Services in the Federal Register, listed in the column marked "Payment Rate," except that:

(1) end-stage renal disease hemodialysis for outpatient, per treatment is paid in accordance with composite rate methodology for the Medicare Program in effect prior to April 1, 2005.
(2) effective July 1, 2019, partial hospitalization is paid the lower of the submitted charge or a~~n hourly rate~~ per diem of ~~that is $69.55~~ $322.40 for adults and ~~$45.36~~ $217.17 for children.

If there is no Ambulatory Payment Classification rate, outpatient hospital facility services are paid the lower of:

(1) Submitted; or
(2) 80% of the 1990 average submitted charge.

If there is no Ambulatory Payment Classification rate or an 80% of the 1990 average submitted charge, outpatient hospital facility services are paid at the consumer price index backdown.

2.a. Outpatient hospital services.
~~Effective July 1, 2013, **vaccines** are paid the lower of:~~
~~(1) the submitted charge;~~
~~(2) Medicare allowable; or~~
~~(3) if Medicare has not established a payment amount:~~
~~a. the wholesale acquisition cost; or~~
~~b. the average wholesale price minus 5%.~~
~~Plus the vaccine administration fee paid at the lesser of the submitted charge or the RBRVS rate.~~

~~Payment for vaccines available through the Minnesota Vaccines for Children Program pursuant to §1928 of the Act is described on page 66(b) of the pre-print~~.

~~Effective July 1, 2013, vaccines provided through Minnesota's adult vaccine program are paid only an administration fee equal to the lesser of the submitted charge or Minnesota's regional maximum administration fee for vaccines under the VFC program as published by the Secretary.~~

Outpatient hospitals that administer pediatric vaccines as described in item 5.a., physicians' services, available through the Minnesota Vaccines for Children Program pursuant to §1928 of the Act, are paid for administering the vaccine using the same methodology described in item 5.a.

Additional payment adjustment for Hennepin County Medical Center and Regions Hospital Effective for services delivered on or after July 1, 2009, in recognition of the services provided by the two largest safety net hospitals, an additional adjustment will be made annually, within two years of the close of the federal fiscal year, that is the difference between the Medicaid costs for outpatient

2.a. Outpatient hospital services (cont).

hospital services and the Medicaid payments for outpatient hospital services for the non-state government-owned hospitals that are not critical access hospitals. Total additional payments shall be determined based on a comparison of Medicaid payments to the hospitals and the hospital's Medicaid costs for the most recent state plan rate year available as reported to DHS under 42 CFR §447.299 (10)and (9).

Payments will be distributed to the Hennepin County Medical Center and Regions Hospital as follows:

(1) Determine the difference between Medicaid costs and Medicaid payments for outpatient hospital services as reported under 42 CFR §447.299(10) and (9) for the most recent year, for each of the non-state government-owned hospitals that are not critical access hospitals.

(2) Calculate a ratio for each of the two hospitals receiving a payment under this section that is equal to:

the FFS Medicaid outpatient hospital payments to each of the two hospitals receiving payments under this section,

divided by the sum of the Medicaid payments for outpatient hospital services to the two hospitals receiving payments under this section.

(3) Apply the ratio computed in step (2) to the difference between the sum of the amounts computed in step (1) for all of the non-state government-owned hospitals that are not critical access hospitals.

Freestanding ambulatory surgical center facility services or facility components are paid in accordance with the methodology in item 9, Clinic services.

Other outpatient hospital services as paid using the same methodology in item 5.a., Physicians' services.

Laboratory services are paid using the same methodology in item 3, Other laboratory and x-ray services.

2.a. Outpatient hospital services, (cont.)

Outpatient chemical abuse programs services are paid using the same methodology in item 13.d., Rehabilitative services.

The base rates as described in this item are adjusted by the following clauses of Supplement 2 of this Attachment:

A. IHS/638 Facilities.
B. Critical Access Hospitals paid on a cost-payment system.
C TPL.
D. MinnesotaCare tax rate adjustment.
E. Modifiers subject to an increase in base payment rate.
K. Copay converted to $2.50 provider rate reduction.
M. Rate decrease effective 07/01/02.
N. Rate decrease effective 03/01/03.
R. Professional services rate decrease effective 7/1/09.
S. Professional services rate decrease effective 7/1/10.
U. Facility services decrease 07/01/09.
Z. Outpatient hospital facility rate decrease 2011.
aa. ~~Renal dialysis rates are adjusted by m~~ Miscellaneous services and materials rate decrease 2011.
gg. Miscellaneous services and materials rate increase effective September 1, 2014.
jj. Rate increase for miscellaneous services, effective July 1, 2015.

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic.

A clinic receives payment based on payment methodology in effect on December 31, 2000 until its prospective payment system (PPS) rate(s) is/are determined in accordance with §1902(bb) of the Social Security Act. The Department will reconcile a clinic's payments back to January 1, 2001 when the clinic's PPS rate(s) is/are determined. The PPS and alternative payment methodology (APM I, APM IV ~~APM II, and APM III~~) rates for clinics will include a rate for dental services, if provided, and a rate for all other rural health clinic services of the provider or provider group. Hereinafter, "all other rural health clinic services of the provider or provider group" will be referred to as "medical services."

Prospective Payment System (PPS) Methodology

Rates are computed using a clinic's fiscal year trended forward to December 31, 2000. For the purposes of compliance with §1902(bb)(6) of the Act, the inflation of the rate will occur each year on January 1. January 1 through December 31 will be the "fiscal year." If applicable, the clinic must provide information regarding changes in the scope of services, including the budgeted cost of providing new services and any projected increase or decrease in the number of encounters due to the change. Any adjustment to the clinic's rate for changes in the scope of services will be effective on the first day of the month following the scope of services change. When determination of the revised PPS rate occurs after the revised rate's effective date, retroactive claims adjustments to the revised rate will be made back to the effective date.

In order to comply with §1902(bb) of the Act, the Department utilizes a formula using a clinic's fiscal year 1999 and fiscal year 2000 cost report information trended forward to December 31, 2000. The trended costs for the two fiscal years are combined and divided by the combined encounter information for the two years, resulting in the average cost rate. Encounters include all face-to-face encounters provided by clinic professionals, including all encounters provided by clinic staff outside of the clinic to clinic patients.

In order to comply with §1902(bb)(4) of the Act, for a clinic that first qualifies as a clinic provider beginning on or after fiscal year 2000, the Department will compare the new clinic to other clinics in the same or adjacent areas with similar case loads. If no comparable provider exists, the Department will compute a clinic-specific rate based upon the clinic's budget or historical costs adjusted for changes in the scope of services.

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic (continued).

Alternative Payment Methodology I

This alternative payment methodology is not available for dates of service on and after January 1, 2021.

For a rural health clinic paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, the methodology is 100% of cost as determined using Medicare cost principles, plus: 1)an additional annual payment described below, for state fiscal year 2011 and thereafter which includes a Department medical education payment for each state fiscal year and distributed to a sponsoring institution prior to April 30 of each year for the previous state fiscal year for distribution to Medical Assistance-enrolled teaching clinics; 2) qualifying payments for meeting the incentive criteria for achieving optimal diabetic or cardiovascular care as described below in item C; 3) effective for services provided on or after July 1, 2010, qualifying payments for health care home services as described in item D; and 4) effective for services provided on or after July 1, 2016, qualifying payments for behavioral health home services as described in item E.

The Department will pay for clinic services as follows:

A. A clinic will be paid for the reasonable cost of clinic services and other ambulatory services, less the cost of providing dental services, on the basis of the cost reimbursement principles in 42 C.F.R. Part 413. The Department will pay for medical services, less the costs of providing dental services, at a single rate per visit based on the cost of all services furnished by the clinic.

B. A clinic will be paid for providing dental services at a rate per visit based on the cost of dental services furnished by the clinic.

C. Effective July 1, 2007, through June 30, 2009, eligible rural health clinics are paid an additional $125 plus 2% every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:
   - Blood pressure less than 140/90; and
   - Lipids less than 100; and
   - Patient is taking aspirin daily if over age 40; and
   - Patient is not using tobacco; and
   - For diabetic only, Hemoglobin A1c levels at less than 8.

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic. (continued)

Each recipient must have had at least two prior office visits with the claiming clinic within the six months before the submission of the claim for the additional payment. Eligible clinics must demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. Clinics must submit documentation of the provision of specific services and complete clinical results per recipient that meet the above criteria for optimal diabetic and/or cardiovascular care. Effective for services provided on or after January 1, 2020, the rate adjustment is $250 every six months when all of the above criteria are met.

D. Effective for services provided on or after January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 1-3 major chronic conditions receiving Group 1 health care home services is the lower of:
   - Submitted charge; or
   - $10.14.

   Effective for services provided on or after January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 4-6 major chronic conditions receiving Group 2 health care home services, is the lower of:
   - Submitted charge; or
   - $20.27.

   Effective for services provided on or after January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 7-9 major chronic conditions receiving Group 3 health care home services is the lower of:
   - Submitted charge; or
   - $40.54.

   Effective for services provided on or after January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:
   - Submitted charge; or
   - $60.81.

2.b. Rural health clinic services and other ambulatory services thatare covered under the plan and furnished by a rural health clinic. (continued)

For each of the Groups 1-4 above, the payment rates listed will be increased by 15% if either of the following apply:

- The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their health care; or
- The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.

E. Effective for services provided on or after July 1, 2016, for clinics certified as meeting the behavioral health home qualifications, and payment criteria, described in Attachment 3.1-H, payment for BHH services is $245.00 per member, per month. During the recipient's first six months of participation, the behavioral health home will receive an enhanced payment rate of $350.00 per member, per month.

The base rates as described in this item are adjusted by paragraph cc. of Supplement 2 entitled, Supplemental Payment for Medical Education.

Alternative Payment Methodology II (reserved)

~~For a rural health clinic paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, the methodology is the clinic's PPS rate plus 4 percent through State Fiscal Year 2005.~~

~~Effective for services provided on or after January 1, 2020, the methodology is the clinic's PPS rate plus an additional annual payment described below, which includes a Department medical education payment made for each state fiscal year to a sponsoring institution prior to April 30 of each year for the previous state fiscal year for distribution to Medical Assistance enrolled teaching clinics; 2) qualifying payments for meeting incentive criteria for achieving optimal diabetic or cardiovascular care as described below in item A; 3) qualifying payments for health care home services as described in item B; 4) qualifying payments for behavioral health home services as described in item C.~~

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic. (continued)

~~Effective for services provided on or after July 1, 2010January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 7-9 major chronic conditions receiving Group 3 health care home services is the lower of:~~

- ~~Submitted charge; or~~
- ~~$40.54, plus 2 percent.~~

~~Effective for services provided on or after July 1, 2010January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:~~

- ~~Submitted charge; or~~
- ~~$60.81, plus 2 percent.~~

~~For each of the Groups 1-4 above, the payment rates listed will be increased by 15% if either of the following apply:~~

- ~~The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their health care; or~~
- ~~The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.~~

~~C. Effective for services provided on or after July 1, 2016January 1, 2020, for clinics certified as meeting the behavioral health home qualifications, and payment criteria, described in Attachment 3.1-H, payment for BHH services is $245.00 per member, per month. During the recipient's first six months of participation, the behavioral health home will receive an enhanced payment rate of $350.00 per member, per month.~~

~~The base rates as described in this item are adjusted by paragraph cc. of Supplement 2 entitled, Supplemental Payment for Medical Education.~~

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic. (continued)

~~**Alternative Payment Methodology III**~~

~~For a rural health clinic paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, the methodology reimburses the clinic for a single medical visit at either the clinic's PPS rate, APM I rate, or APM II rate as agreed to by the clinic. When the clinic provides services to a patient through both a somatic medical and mental health encounter on the same day, the rate for the visit will be 200% of what would otherwise be paid under the PPS, APM I, or APM II methodologies.~~

~~**Payment**~~

~~A clinic providing services under a contract with a Medicaid managed care entity (MCE) will receive monthly state supplemental payments for the cost of providing such services. The supplemental payments are the difference between the payments the clinic receives from the MCE and the payments the clinic would have received in accordance with the PPS or chosen alternative payment methodology (APM I, APM II, or APM III).~~

~~At the end of the clinic's fiscal year, the total amount of supplemental and MCE entity payments received will be reviewed against the amount that the actual number of visits provided under the clinic's contract with the MCE would have yielded under the clinic's chosen Medicaid fee-for-service alternative payment methodology (PPS, APM I, APM II, or APM III). The clinic will be paid the difference between the amount calculated using the Medicaid fee-for-service alternative payment methodology and actual number of visits, and the total amount of supplemental and MCE payments received, if the Medicaid fee-for-service alternative amount exceeds the total amount of supplemental and MCE payments. The clinic will refund the difference between the Medicaid fee-for-service alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received, if the Medicaid fee-for-service alternative amount is less than the total amount of supplemental and MCE payments.~~

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic. (continued)

~~For rural health clinic payments, "visit" means a face-to-face encounter between a clinic patient and any health professional whose services are paid under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.~~

~~The State uses the clinic's audited Independent Rural Health Clinic/Freestanding Federally Qualified Health Center worksheet, Statistical Data, and Certification Statement to establish payment rates. The State makes adjustments for:~~

~~A. Medicaid coverage of services that differs from Medicare coverage;~~

~~B. the applicable visits; and~~

~~C. the establishment of a separate dental payment rate, if dental services are provided.~~

~~The State limits like services for Medicare and Medicaid to the respective Medicare limit for the year. Time periods that span more than one calendar year are limited to the respective Medicare limit for each time period.~~

~~For purposes of this item, "rural health clinic services" means those services listed in 42 CFR §440.20(b); "ambulatory services" means those services listed in 42 CFR §440.20(c).~~

~~The base rates as described in this item are adjusted by the following paragraph(s) of Supplement 2:~~

~~cc. Supplemental payment for medical education~~

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic. (continued)

Alternative Payment Methodology IV

A rural health clinic paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, shall be reimbursed a single encounter rate for each medical or dental service. If a medical service and a dental service are provided to the same patient on the same day, the clinic will be reimbursed both the medical and the dental encounter rate.

For rural health clinic payments, "visit" means a face-to-face encounter between a clinic patient and any health professional whose services are paid under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

The State uses the clinic's audited Independent Rural Health Clinic/Freestanding Federally Qualified Health Center worksheet, Statistical Data, and Certification Statement to establish payment rates. The State makes adjustments for:

A. Medicaid coverage of services that differs from Medicare coverage;
B. the applicable visits; and
C. the establishment of a separate dental payment rate, if dental services are provided.

The State limits like services for Medicare and Medicaid to the respective Medicare limit for the year. Time periods that span more than one calendar year are limited to the respective Medicare limit for each time period.

For purposes of this item, "rural health clinic services" means those services listed in 42 CFR §440.20(b); "ambulatory services" means those services listed in 42 CFR §440.20(c).

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic. (continued)

Payment

The medical encounter rate shall be computed based on the clinic's allowable base year(s) medical costs divided by the number of qualifying medical encounters in the base year(s). The dental encounter rate shall be computed based on the clinic's allowable base year(s) dental costs divided by the number of qualifying dental encounters in the base year(s). Allowable costs are determined in accordance with current applicable Medicare cost principles including direct patient care costs and patient-related support services costs. Qualifying encounters are encounters in which the patient is seen by a practitioner eligible to independently bill for the services provided.

Payment rates for services delivered on or after January 1, 2021 will use the clinic's allowable costs as reported on the Medicare cost report and encounters for the clinic fiscal years ending 2017 and 2018. The base year rate shall be trended to the payment year using the CMS FQHC Market Basket inflation factor less the productivity adjustment.

Clinic encounter rates calculated under this APM shall be inflated annually using the FQHC Market Basket, less the productivity adjustment, until the next rebasing.

Every two years these rates will be rebased using the allowable costs, as reported on the Medicare cost report, and encounters from the clinic fiscal years that are three and four years prior to the rebasing year.

Treatment of Health Care Education Program Costs

A clinic's costs related to participation in health care eduction programs shall be considered allowable costs. The total allowable costs will be reduced by any Medical Education and Research (MERC) grants received to compensate training facilities for a portion of the clinical training costs.

Change in Scope Adjustments

Payment adjustments due to changes in scope will not be implemented unless the change in scope results in a payment increase or decrease of 2.5 percent or higher. The effective date of the payment adjustment will be the later of:

a. The date the Health Resources and Services Administration (HRSA) approves the change in scope or

b. The effective start date of the services included in the change in scope.

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic. (continued)

If HRSA approval of the change in scope is not required. A clinic may submit a change in scope request directly to the Department of Human Services. The payment adjustment effective date for change in scope requests submitted directly to the Department will be the later of:

a. The date the Department received the clinic's change in scope request or
b. The effective start date of the services included in the change in scope.

Initial change in scope adjustments may be computed using estimated costs and encounters. Payment adjustments based on estimated costs or encounters will be reviewed no later than 45 days following the date that is one year after the effective date of the payment adjustment. If the rate determined using the estimated costs or encounters differs from the rate calculated using actual cost and encounters by more than 2.5 percent, the rate based on estimated costs or encounters shall be adjusted to the rate based on actual costs and encounters retroactive to the effective date of the scope change payment adjustment.

In addition to the cost based encounter rate, qualifying clincs will receive the following health care home or behavioral health home payments:

A. Effective for services provided on or after January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 1-3 major chronic conditions receiving Group 1 health care home services is the lower of:
- Submitted charge; or
- $10.14.

B. Effective for services provided on or after January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 4-6 major chronic conditions receiving Group 2 health care home services, is the lower of:
- Submitted charge; or
- $20.27.

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic. (continued)

C. Effective for services provided on or after January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 7-9 major chronic conditions receiving Group 3 health care home services is the lower of:

- Submitted charge; or
- $40.54.

D. Effective for services provided on or after January 1, 2020, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:

- Submitted charge; or
- $60.81.

For each of the Groups A through D above, the payment rates listed will be increased by 15% if either of the following apply:

- The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their health care; or
- The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.

E. Effective for services provided on or after July 1, 2016, for clinics certified as meeting the behavioral health home qualifications, and payment criteria, described in Attachment 3.1-H, payment for BHH services is $245.00 per member, per month. During the recipient's first six months of participation, the behavioral health home will receive an enhanced payment rate of $350.00 per member, per month.

The base rates as described in this item are adjusted by paragraph cc. of Supplement 2 entitled, Supplemental Payment for Medical Education.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC.

A FQHC receives payment based on payment methodology in effect on December 31, 2000 until its prospective payment system (PPS) rate(s) is/are determined in accordance with §1902(bb) of the Social Security Act. The Department will reconcile a FQHC's payments back to January 1, 2001 when the FQHC's PPS rate(s) is/are determined. The PPS and alternative payment methodology (APM I, APM IV,APM V) rates for FQHCs will include a rate for dental services, if provided, and a rate for all other FQHC services of the provider or provider group. Hereinafter, "all other FQHC services of the provider or provider group" will be referred to as "medical services."

Prospective Payment System (PPS) Methodology

Rates are computed using a FQHC's fiscal year trended forward to December 31, 2000. For the purposes of compliance with §1902(bb)(3) of the Act, the inflation of the rate will occur each year on January 1. January 1 through December 31 will be the "fiscal year." If applicable, the FQHC must provide information regarding changes in the scope of services, including the budgeted cost of providing new services and any projected increase or decrease in the number of encounters due to the change. Any adjustment to the FQHC's rate for changes in the scope of services will be effective on the first day of the month following the scope of services change. When determination of the revised PPS rate occurs after the revised rate's effective date, retroactive claims adjustments to the revised rate will be made back to the effective date.

In order to comply with §1902(bb) of the Act, the Department utilizes a formula using a FQHC's fiscal year 1999 and fiscal year 2000 cost report information trended forward to December 31, 2000. The trended costs for the two fiscal years are combined and divided by the combined encounter information for the two years, resulting in the average cost rate. Encounters include all face-to-face encounters provided by FQHC professionals, including all encounters provided by FQHC staff outside of the FQHC to FQHC patients.

In order to comply with §1902(bb)(4) of the Act, for a FQHC that first qualifies as a FQHC providers beginning on or after fiscal year 2000, the Department will compare the new FQHC to other FQHCs in the same or adjacent areas with similar case loads. If no comparable provider exists, the Department will compute a FQHC-specific rate based upon the FQHC's budget or historical costs adjusted for changes in the scope of services.

Each APM pays at least the amount paid under Prospective Payment System (PPS). Each individual FQHC agrees to receive the APM. The APM is compared to the PPS amount annually.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

Alternative Payment Methodology I

This alternative payment methodology is not available for services delivered on and after January 1, 2021.

For a FQHC paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, an interim rate is established, subject to reconciliation at the end of the cost reporting period. The alternative payment methodology is 100% of cost as determined using Medicare cost principles, plus: 1)an additional annual payment described below, for state fiscal year 2011 and thereafter, which includes a Department medical education payment made for each state fiscal year to a sponsoring institution prior to April 30 of each year for the previous state fiscal year for distribution to Medical Assistance enrolled teaching FQHCs; 2) qualifying payments for meeting the incentive criteria for achieving optimal diabetic or cardiovascular care as described below in item C; 3) effective for services provided on or after July 1, 2010, qualifying payments for health care home services as described in item D; and 4) effective for services provided on or after July 1, 2016, qualifying payments for behavioral health home services as described in item E.

The Department will pay for FQHC services as follows:

A. A FQHC will be paid for the reasonable cost of FQHC services and other ambulatory services, less the cost of providing dental services, on the basis of the cost reimbursement principles in 42 CFR Part 413. The Department will pay for medical services, less the cost of providing dental services, at a single rate per visit based on the cost of all services furnished by the FQHC.

B. A FQHC will be paid for providing dental services at a rate per visit based on the cost of dental services furnished by the FQHC.

C. Effective July 1, 2007, through June 30, 2009, eligible FQHCs are paid an additional $125 plus 2% every six months for each recipient for whom the FQHC demonstrates optimal diabetic and/or cardiovascular care which includes:

- Blood pressure less than 140/90; and
- Lipids less than 100; and
- Patient is taking aspirin daily if over age 40; and
- Patient is not using tobacco; and
- For diabetic only, Hemoglobin A1c levels at less than 8.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

Each recipient must have had at least two prior office visits with the claiming FQHC within the six months before the submission of the claim for the additional payment. Eligible FQHCs must demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. To qualify for the rate adjustment, the FQHC must submit documentation of the provision of specific services and complete clinical results per recipient that meet the criteria for optimal diabetic and/or cardiovascular care. Effective for services provided on or after January 1, 2020, the rate adjustment is $250 every six months when all of the above criteria are met.

A. Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 1-3 major chronic conditions receiving Group 1 health care home services is the lower of:
   - Submitted charge; or
   - $10.14.

   Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 4-6 major chronic conditions receiving Group 2 health care home services, is the lower of:
   - Submitted charge; or
   - $20.27.

   Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 7-9 major chronic conditions receiving Group 3 health care home services is the lower of:
   - Submitted charge; or
   - $40.54.

   Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:
   - Submitted charge; or
   - $60.81.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

For each of the Groups 1-4 above, the payment rates listed will be increased by 15% if either of the following apply:

- The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their health care; or
- The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.

E. Effective for services provided on or after July 1, 2016, for FQHCs certified as meeting the behavioral health home qualifications, and payment criteria, described in Attachment 3.1-H, payment for BHH services is $245.00 per member, per month. During the recipient's first six months of participation, the behavioral health home will receive an enhanced payment rate of $350.00 per member, per month.

The base rates as described in this item are adjusted by paragraph cc. of Supplement 2 entitled, Supplemental Payment for Medical Education.

Alternative Payment Methodology II (reserved)

~~For a FQHC paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, the methodology is the FQHC's PPS rate plus 4 percent through State Fiscal Year 2005.~~

~~Effective for services provided on or after January 1, 2020, the methodology is the FQHC's PPS rate plus: 1) a medical education payment made for each state fiscal year to a sponsoring institution prior to April 30 of each year for the previous state fiscal year for distribution to Medical Assistance enrolled teaching FQHCs; 2) qualifying payments for meeting incentive criteria for achieving optimal diabetic or cardiovascular care as described below in item A; 3) qualifying payments for health care home services as described in item B; and 4) qualifying payments for behavioral health home services as described in item C~~.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

~~A. Effective July 1, 2007, through June 30, 2009, eligible rural health clinics are paid an additional $125 plus 2% every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:~~

- ~~Blood pressure less than 140/90; and~~
- ~~Lipids less than 100; and~~
- ~~Patient is taking aspirin daily if over age 40; and~~
- ~~Patient is not using tobacco; and~~
- ~~For diabetic only, Hemoglobin A1c levels at less than 8.~~

~~Each recipient must have had at least two prior office visits with the claiming clinic within the six months before the submission of the claim for the additional payment. Eligible clinics must demonstrate the above optimal diabetic and/or provision of specific services and complete clinical results per recipient that meet the criteria for optimal diabetic and/or cardiovascular care. Effective for services provided on or after January 1, 2020, the rate adjustment is $250 every six months when all of the above criteria are met.~~

~~B. Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 1-3 major chronic conditions receiving Group 1 health care home services is the lower of:~~

- ~~Submitted charge; or~~
- ~~$10.14.~~

~~Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 4-6 major chronic conditions receiving Group 2 health care home services is the lower of:~~

- ~~Submitted charge; or~~
- ~~$20.27.~~

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

~~Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 7-9 major chronic conditions receiving Group 3 health care home services is the lower of:~~

- ~~Submitted charge; or~~
- ~~$40.54.~~

~~Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:~~

- ~~Submitted charge; or~~
- ~~$60.81.~~

~~For each of the Groups 1-4 above, the payment rates listed will be increased by 15% if either of the following apply:~~

~~The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their health care; or~~

- ~~The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.~~

~~C. Effective for services provided on or after July 1, 2016, for clinics certified as meeting the behavioral health home qualifications, and payment criteria, described in Attachment 3.1-H, payment for BHH services is $245.00 per member, per month. During the recipient's first six months of participation, the behavioral health home will receive an enhanced payment rate of $350.00 per member, per month.~~

~~The base rates as described in this item are adjusted by paragraph cc. of Supplement 2 entitled, Supplemental Payment for Medical Education~~.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

Alternative Payment Methodology III (reserved)

~~For a FQHC paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, the methodology reimburses the FQHC for a single medical visit at either the FQHC's PPS rate, APM I rate, or APM II rate as agreed to by the FQHC. When the FQHC provides services to a patient through both a somatic medical and mental health encounter on the same day, the rate for the visit will be 200% of what would otherwise be paid under the PPS, APM I, or APM II methodologies.~~

~~Payment~~

~~A FQHC providing services under a contract with a Medicaid managed care entity (MCE) will receive monthly state supplemental payments for the cost of providing such services. The supplemental payments are the difference between the payments the FQHC receives from the MCE and the payments the FQHC would have received in accordance with the PPS or chosen alternative payment methodology (APM I, APM II, or APM III).~~

~~At the end of the FQHC's fiscal year, the total amount of supplemental and MCE entity payments received will be reviewed against the amount that the actual number of visits provided under the FQHC's contract with the MCE would have yielded under the FQHC's chosen Medicaid feefor-service alternative payment methodology (PPS, APM I, APM II, or APM III). The FQHC will be paid the difference between the amount calculated using the Medicaid fee-for-service alternative payment methodology and actual number of visits, and the total amount of supplemental and MCE payments received, if the Medicaid fee forservice alternative amount exceeds the total amount of supplemental and MCE payments. The FQHC will refund the difference between the Medicaid fee-for-service alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received, if the Medicaid fee-for-service alternative amount is less than the total amount of supplemental and MCE payments.~~

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

~~For FQHC payments, "visit" means a face-to-face encounter between a FQHC patient and any health professional whose services are paid under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.~~

~~The State uses the FQHC's audited Independent Rural Health Clinic/Freestanding Federally Qualified Health Center worksheet, Statistical Data, and Certification Statement to establish payment rates. The State makes adjustments for:~~

~~A. Medicaid coverage of services that differs from Medicare coverage;~~
~~B. the applicable visits; and~~
~~C. the establishment of a separate dental payment rate, if dental services are provided.~~

~~The State limits like services for Medicare and Medicaid to the respective Medicare limit for the year. Time periods that span more than one calendar year are limited to the respective Medicare limit for each time period.~~

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

Alternative Payment Methodology IV

A FQHC paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, shall be reimbursed a single encounter rate for each medical or dental service. If a medical service and a dental service are provided to the same patient on the same day, the clinic will be reimbursed both the medical and the dental encounter rate.

For federally qualified health center payments, "visit" means a face-to-face encounter between a clinic patient and any health professional whose services are paid under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the firstencounter, suffers illness or injury requiring additional diagnosis or treatment.

The State uses the clinic's audited Independent Rural Health Clinic/Freestanding Federally Qualified Health Center worksheet, Statistical Data, and Certification Statement to establish payment rates. The State makes adjustments for:

A. Medicaid coverage of services that differs from Medicare coverage;
B. the applicable visits; and
C. the establishment of a separate dental payment rate, if dental services are provided.

The State limits like services for Medicare and Medicaid to the respective Medicare limit for the year. Time periods that span more than one calendar year are limited to the respective Medicare limit for each time period.

For purposes of this item, "rural health clinic services" means those services listed in 42 CFR §440.20(b); "ambulatory services" means those services listed in 42 CFR §440.20(c)

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

Payment

The encounter rate shall be computed based on the clinic's allowable base year(s) costs divided by the number of qualifying encounters in the base year(s). Allowable costs are deterimined in accordance with current applicable Medicare cost prinicples including direct patient care costs and patient-related support services costs. Qualifying encounters are encounters in which the patient is seen by a practioner eligible to independently bill for the services provided.

Payment rates for services delivered on or after January 1, 2021 will use the clinic's allowable costs as reported on the Medicare cost report and encounters for the clinic fiscal years ending 2017 and 2018. The base year rate shall be trended to the payment year using the CMS FQHC Market Basket inflation factor less the productivity adjustment.

Clinic encounter rates shall be inflated annually using the FQHC Market Basket, less the productivity adjustment, until the next rebasing.

Clinic encounter rates shall be rebased every two years using the allowable costs, as reported on the Medicare cost report, and encounters from the clinic fiscal years that are three and four years prior to the rebasing year.

Treatment of Health Care Education Program Costs

A clinic's costs related to participation in health care eduction programs shall be considered allowable costs. The total allowable costs will be reduced by any Medical Education and Research (MERC) grants received to compensate training facilities for a portion of the clinical training costs.

Change in Scope Adjustments

Payment adjustments due to changes in scope will not be implemented unless the change in scope results in a payment increase or decrease of 2.5 percent or higher. The effective date of the payment adjustment will be the later of:

a. The date the Health Resources and Services Administration (HRSA) approves the change in scope or
b. The effective start date of the services included in the change in scope.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

If HRSA approval of the change in scope is not required. A clinic may submit a change in scope request directly to the Department of Human Services. The payment adjustment effective date for change in scope requests submitted directly to the Department will be the later of:

a. The date the Department received the clinic's change in scope request or
b. The effective start date of the services included in the change in scope.

Initial change in scope adjustments may be computed using estimated costs and encounters. Payment adjustments based on estimated costs or encounters will be reviewed no later than 45 days following the date that is one year after the effective date of the payment adjustment. If the rate determined using the estimated costs or encounters differs from the rate calculated using actual cost and encounters by more than 2.5 percent, the rate based on estimated costs or encounters shall be adjusted to the rate based on actual costs and encounters retroactive to the effective date of the scope change payment adjustment.

In addition to the cost based encounter rate, qualifying clincs will receive the following health care home or behavioral health home payments:

A. Effective for services provided on or after January 1, 2021, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 1-3 major chronic conditions receiving Group 1 health care home services is the lower of:
   - Submitted charge; or
   - $10.14.

B. Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 4-6 major chronic conditions receiving Group 2 health care home services, is the lower of:
   - Submitted charge; or
   - $20.27.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

C. Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 7-9 major chronic conditions receiving Group 3 health care home services is the lower of:
   - Submitted charge; or
   - $40.54.

D. Effective for services provided on or after January 1, 2020, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:
   - Submitted charge; or
   - $60.81.

   For each of the Groups A through D above, the payment rates listed will be increased by 15% if either of the following apply:
   - The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their health care; or

   - The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.

E. Effective for services provided on or after July 1, 2016, for FQHCs certified as meeting the behavioral health home qualifications, and payment criteria, described in Attachment 3.1-H, payment for BHH services is $245.00 per member, per month. During the recipient's first six months of participation, the behavioral health home will receive an enhanced payment rate of $350.00 per member, per month.

~~The base rates as described in this item are adjusted by paragraph cc. of Supplement 2 entitled, Supplemental Payment for Medical Education.~~

Alternative Payment Methodology V - Tribal FQHC

Alternative Payment Methodology (APM) V is effective January 1, 2025. IHS/Tribal 638 facilities may elect to have an FQHC designation in addition to their tribal 638 clinic designation. IHS/Tribal 638 clinics that elect this option agree to be paid the Indian Health Service(IHS) All Inclusive Rate (AIR) for services provided under the FQHC designation in the same manner as described in paragraph A of Supplement 2 to this attachment.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (Continued)

DHS will establish a Prospective Payment System (PPS) methodology for the Tribal facility so that the agency can determine on an annual basis that the published, all-inclusive rate is higher than the PPS rate.
The PPS rate is established by reference to payment to one or more other clinics in the same or adjacent areas. Tribal FQHCs are not required to report their costs for the purposes of establishing a PPS rate.

To elect the FQHC designation, Tribes must file a signed Assurance Statement with DHS. Tribes have the option to withdraw the Assurance Statement and end the tribal FQHC designation at any time.

3. Other laboratory and x-ray services.

X-ray services are paid using the same methodology as item 5.a., Physicians' services.

Laboratory services are paid as follows:

(1} Services for which a Medicare upper payment limit applies are paid the lower of:

a) submitted charge; or

(b) the Medicare rate of the local carrier. If the local carrier does not have a current Medicare rate, then the previously established Medicare rate, if available, or according to the methodology below.

(2) Other services are paid the lower of:

(a) submitted charge; or

(b) one of the following:

1} 50th percentile of the charges submitted by all providers of the service (except dentists) in the calendar year specified in legislation governing maximum payment rates, less 25%;

2) 50th percentile of the charges submitted by all providers of the service {except dentists) in years subsequent to the calendar year specified in legislation governing maximum payment rates, down by the appropriate CPI formula, less 25%;

3) an average of a number of independent laboratory providers' charges, less 25%;

4) payment rates for comparable services; or

5) the Medicare rate.

(c) effective July 1, 2007, the sticker fee for laboratory specimens administered by the Department of Health is $25.00.

(d) effective July 1, ~~1997~~ 2025,the payment for newborn screening for metabolic disease administered by the Minnesota

3. Other laboratory and x-ray services (continued).

Department of Health is ~~$21.00~~ included in the fee schedule.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of newborn screening for metabolic disease. The agency's fee schedule rate was set as of July 1, 2025 and is effective for services provided on or after that date. All rates are published on the agency's website: ***https://mn.gov/dhs/partners-and-providers/policies-procedures/minnesota-health-care-programs/provider/billing/fee-schedule/mhcp.jsp***

The base rate as described in this item is adjusted by the following clauses of Supplement 2 of this Attachment.

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
D. MinnesotaCare Tax Rate Adjustment
E. Modifiers
H. Medicare Cap
I. Exceptions to payment methodology and reconstructing a rate
U. Facility services 2009 rate decrease
W. Radiology rates are adjusted by the professional services rate decrease 2011.
aa. Laboratory rates are adjusted by the miscellaneous services and materials rate decrease 2011.
gg. Miscellaneous services and materials rate increase effective September 1, 2014.

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

See Attachment 4.19-D.

4.b.Early and periodic screening, diagnosis, and treatment services.

EPSDT (in Minnesota, Child & Teen Checkup) services are paid the lower of the submitted charge or the 75th percentile of screening charges submitted by providers of the service during the period of July 1 to June 30, 2010. The adjustment necessary to reflect the 75th percentile is effective on October 1, 2010.

Effective January 1, 2002, provider travel time is covered if a recipient's individual treatment plan requires the provision of mental health services outside of the provider's normal place of business. Travel time is paid as a supplement to the payment for the associated covered service. Travel time is paid at the lower of the submitted charge or 45 cents per minute. This does not include travel time included in other billable services.

A. With the exceptions listed below, children's therapeutic services and supports not provided by IHS/638 facilities are paid the lower of the submitted charge or the Resource Based Relative Value Scale rate.

The children's therapeutic services and supports below are paid the lower of the submitted charge or the listed rate.

H0031 UA ~~UD~~ Functional Assessment: ~~$19.81 per 15 minute unit~~$82.44 per session
H0032 UA ~~UD~~ Service Plan Development: ~~$19.81 per 15 minute unit~~$82.44 per session
H2014 UA CTSS Skills Training, Individual: $12.80 per 15 minute unit
H2014 UA HQ CTSS Skills Training, Group: $8.60 per 15 minute unit
H2014 UA HR CTSS Skills Training, Family: $16.67 per 15 minute unit
H2015 UA CTSS Crisis Assistance: $13.65 per 15 minute unit
H2019 UA CTSS Mental Health Behavioral Aide-level 1: $6.03 per 15 minute unit
H2019 UA HE CTSS Direction of Mental Health Behavioral Aide by Mental Health Professional or Mental Health Practitioner: $8.80 per 15 minute unit
H2019 UA HM CTSS Mental Health Behavioral Aide-level 2:$7.89 per 15 minute unit

4.b.Early and periodic screening, diagnosis, and treatment services.

H2012 UA HK Behavioral Health Day Treatment: $48.30 per one hour unit

H2012 UA U6 HK Behavioral Health Day Treatment (Interactive):$56.81 per one hour unit

Payment for behavioral health day treatment is based on a calculation of the average historical cost of providing the component services of psychotherapy and skills training.

The Department monitors the provision of day treatment services via site reviews at re-certification, and when an allegation of improper billing or maltreatment is received. Provider data is compared to MMIS data to ensure adequate service provision.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

~~7. Effective January 1,2008, all mental health professional or mental health practitioner direction of MHBAs, except those described below in items 8, paragraphs 1, 2, and 3), are paid the lower of the submitted charge or 23.7 percent over the rate in effect on December 31, 2007.~~

~~8. Effective July 1, 2007, mental health practitioner direction of MHBA's is paid the lower of the submitted charge or 23.7% over the rates in effect on January 1, 2006, when provided by:~~

~~1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;~~

~~2) community mental health centers described in Attachment 3.1-A and 3.1-B at item 6.d.A; or~~

~~3) essential community providers as designated under Minnesota Statutes §62Q.19, in mental health clinics and centers certified under Minnesota Rules, parts 9520.0750 to 9520.0870, or hospital outpatient psychiatric departments.~~

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

Crisis response services are paid as follows:

Crisis assessment, intervention and crisis stabilization services are paid:

-for doctoral prepared mental health professionals, the lower of the submitted charge or ~~$148.77 per 60-minute unit~~$37.19 per 15-minute unit;

-for master's prepared mental health professionals, the lower of the submitted charge or ~~$119.01 per 60-minute unit~~$29.75 per 15-minute unit; or

-for mental health practitioners supervised by mental health professionals, the lower of the submitted charge or ~~$104.13 per 60-minute unit~~$26.03 per 15-minute unit.

IHS/638 facility providers of crisis response services are paid according to the encounter rate specified in Supplement 2 of this Attachment for each face-to-face encounter.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

- **Services provided to recipients with severe emotional disturbance residing in a children's residential treatment facility** is based on the daily rate negotiated by the county. The county will pay the residential facility the full negotiated rate and certify to the Department that the rate paid represents expenditures eligible for the matching Federal medical assistance percentage. The county is responsible for the nonfederal share.

  The Department, using the rate methodology below, determines the medical assistance percentage of the per day negotiated rate and submits a claim to HCFA. The Department returns to the county the Federal medical assistance percentage.

  Rate Methodology

  The negotiated daily rate paid to a children's residential treatment facility is the same for medical assistance-eligible and non medical assistance-eligible individuals.

  Beginning July 1, 2000, the allowable medical assistance daily rate is determined using a statistically valid random day log time study containing various activity categories and an annual facility cost report.

  The time study of facility staff determines the percent of time spent by direct service staff on various specific activity categories constituting allowable and unallowable rehabilitative activities.

  The annual cost report from each facility provides a breakdown of facility costs into the same activity categories utilized in the time study and a breakdown of allowable and unallowable medical assistance costs. The results of the time study determine the amount of salary and fringe benefit costs for direct service staff that are charged to each activity category. Direct costs are those costs attributable to a specific activity and, therefore, are charged directly to that time study activity category. Salary, fringe and direct costs are totaled for each category and then indirect costs are allocated to each category based on the proportion of each category to the total of all facility costs. The proportion of allowable medical assistance costs to total facility costs establishes the percentage of the daily rate eligible for medical assistance payment.

4.b.Early and periodic screening, diagnosis, and treatment services (continued)

Rate Formula
The medical assistance payment is the computed percentage of the daily rate multiplied by the total facility daily rate.

All of the following conditions must be met in order for a claim to be made:

1. residents must be eligible for medical assistance
2. residents received rehabilitative services that day
3. all documentation requirements are met

A residential facility's: daily medical assistance rate will be reviewed and updated quarterly for changes in the negotiated rate and annually for changes in time study or cost data.

Personal care assistant services identified in an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) under the Individuals with Disabilities Education Act (IDEA) and- provided by school districts during the school day to children with IFSPs/lEPs are paid pursuant to the methodology in item 13.d.V Rehabilitative services.

Other EPSDT providers are paid in accordance with the methodology set forth elsewhere in this Attachment for the provider type enrolled to provide the 'service.

The base rates as described in this item are adjusted by the following paragraphs of Supplement 2:

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
D. MinnesotaCare Tax Rate Adjusment effective for service dates beginning 01/01/04
E. Modifiers
G. Community and Public Health Clinics
I. Exceptions to payment methodology and reconstructing a rate

4.b.Early and periodic screening, diagnosis, and treatment services (continued)

O. Rate increase effective 10/1/07 and 7/1/08.
P. Rate increase effective 07/01/07
bb. Reimbursement for costs of services provided by a non-state, government-operated community mental health center
ff. Professional services rate increase effective September 1, 2014

4.b.Early and periodic screening, diagnosis, and treatment services (continued)

Youth ACT services provided by entities with contracts with the Department are paid a regional per diem rate per provider as indicated by the table below. The Department will set rates inclusive of all intensive nonresidential rehabilitative services identified in Attachments 3.1-A and B, section 4.b., item 5, using statewide parameters with assigned values based on regional costs of providing care. To determine this rate, the Department will include and document:

A. the cost for similar services in the geographic region;
B. actual costs incurred by entities providing the services;
C. the intensity and frequency of services to be provided to each client;
D. the degree to which clients will receive services other than services under this section; and
E. the costs of other services that will be separately reimbursed.

The chart below identifies the per diem rate for youth ACT services provided on or after the effective date. The rate is based on the five criteria above. Rates are recalculated annually based on the submitted charges for the individual service components within the geographical regions. Effective for the rate years beginning on and after January 1, 2024, rates for Youth ACT services must be annually adjusted for inflation using the Medicare Economic Index (MEI). 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.

Region	~~**Rate** Eff. 7/1/2021~~	**Rate** Eff. 1/1/2022	Rate Eff.1/1/2023	Rate Eff. 1/1/2024	Rate Eff.1/1/2025
Central	~~$194.49~~	$188.46	$238.28	$283.63	$252.36
Metro	~~$257.42~~	$279.81	$364.54	$435.78	$508.25
Northeast	~~$178.60~~	$178.60	$178.60	$184.61	$190.31
Northwest	~~$185.28~~	$185.28	$185.28	$406.26	$418.81
Southeast	~~$149.63~~	$149.63	$149.63	$154.67	$159.45
Southwest	~~$170.01~~	$170.01	$170.01	$175.73	$181.16

Travel time, as described in item 6.d.A., is paid separately.

4.b.Early and periodic screening, diagnosis, and treatment services.

Effective for services provided on or after July 1, 2013, Family Psychoeducation services are paid in 15 minute units using the same methodology that applies to psychotherapy services in item 5.a. Physicians' services.

In-reach Care Coordination services are paid using the same methodology that applies to in-reach care coordination services in item 5.a., Physicians' services.

Effective for services provided on or after July 1, 2013, **Clinical Care Consultation** services are paid the lower of:

1. the submitted charge, or
2. the state established rate of:
   - 90899U8 (5 – 10 min) $14.10
   - 90899U9 (11 – 20 min) $29.14
   - 90899UB (21 – 30 min) $47.94
   - 90899UC (>30 min) $76.02

If the service is provided over the phone, the state established rate is equal to 75% of the amount listed above.

An entity of the type described in item 4.b, section 1, of Attachment 3.1-A and 3.1-B, may employ a mental health professional, and a clinical trainee, as described in item 6.d.A. of Attachments 3.1-A and 3.1-B, to provide psychotherapy, psychoeducation, crisis assistance, clinical care consultation, and individual treatment plan development as part of an intensive treatment program. Effective for services provided on or after July 1, 2017, payment is the lower of:

1) submitted charge, or
2) the payment rate otherwise specified for the component service under item 4.b. of Attachment 4.19-B, except when an intensive level of therapeutic interventions are provided to foster children and children considered to be at-risk who are living with their legal guardians, at least three days per week for two hours per encounter (or during a subsequent period when reduced units of service are specified in the treatment plan and for no more than 60 days in order to meet the needs of the client and family, or pursuant to a discharge plan to another service or level of care), the payment rate of $386.11 per child per diem. Billing and payment are prohibited for days on which no services are delivered and documented.

Effective for services provided on or after September 1, 2016, **Certified Family Peer Specialist** services are paid the lower of:

1. the submitted charge, or
2. the state established rate of:
   - H0038 HA (individual) $15.02 per 15 minutes
   - H0038 HA HQ (group) $7.55 per 15 minutes

4.b.Early and periodic screening, diagnosis, and treatment services.

Effective for services provided on or after July 1, 2015, payment for **Early Intensive Developmental and Behavioral Intervention (EIDBI)** services is the lower of:

1. Submitted charge, or
2. The resource based relative value scale (RBRVS) calculated rate (if available);

For all other services, payment is the lower of

1. Submitted charge, or
2. the following state agency established rates:

- Comprehensive multi-disciplinary evaluation (CMDE) conducted by a CMDE provider: $~~43.58~~50.12 per 15-minute unit
- Coordinated care conference, per provider per session: $~~97.98~~112.68
- EIDBI intervention with two providers, per 15-minute unit: $~~21.04~~24.20

For the following services, the agency established rate is based on the service being provided by a qualified supervising professional or Level I provider,; the agency established rate is reduced 20% when provided by a Level II provider, or; the agency established rate is reduced by 50% when provided by a Level III provider.

- Individual Treatment Plan (ITP) development: $~~82.44~~94.20 per session
- EIDBI intervention, per 15-minute unit: $~~17.54~~20.18
- Group intervention, per 15-minute unit: $~~5.84~~6.72
- Observation and Direction of EIDBI intervention, per 15- minute unit: $17.5420.18
- Family/caregiver training and counseling, per 15 minute unit: $~~17.54~~20.18
- Group family/caregiver training and counseling, per 15 minute unit: $~~5.84~~6.72

Necessary travel time to provide EIDBI services is paid using the same methodology that applies to provider travel time in item 6.d.A.

4.c. Family planning services and supplies for individuals of child-bearing age.

Family planning providers and public health providers are paid using the same methodology as item 5.a., Physicians' services. ~~Effective July 1, 1993, item 5 becomes item 5.a.~~

Other family planning providers are paid in accordance with the methodology set forth elsewhere in this Attachment for the provider type enrolled to provide the service.

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Effective for services provided on or after January 14, 2014, payment for physician services is the lowest of:

1) submitted charges; or
2) a) The Resource Based Relative Value Scale calculated values(as published by the Centers for Medicare & Medicaid Services in November of the previous calendar year); or
   b) State agency established rate; or
   C) For delivery services, including cesarean delivery services that are not complicated:
   59400, 59510, 59610: $1387.89
   59409, 59514, 59612: $540.00
   59410, 59515, 59614: $696.73

Effective July 1, 2013, **vaccines** are paid the lower of:

(1) the submitted charge;
(2) Medicare allowable; or
(3) if Medicare has not established a payment amount:
   a. the wholesale acquisition cost; or
   b. the average wholesale price minus 5%.

An additional payment for administration of the vaccine will be made at a rate equal to the lesser of the submitted charge, or the RBRVS rate.

Payment for vaccines available through the Minnesota Vaccines for Children Program pursuant to §1928 of the Act is limited to vaccine administration. The state pays for administration of the vaccine at a rate equal to the lower of the submitted charge, or the RBRVS rate. Payment shall not exceed the regional maximum established by the DHHS Secretary.

~~Payment for administration of COVID-19 vaccinations is made at the rates established by Medicare in effect at the time the service is provided. COVID-19 vaccine administration will be paid at 100% of the geographically adjusted (GCPI) Medicare equivalent rates. This rate is limited to cases where vaccine administration is separately reimbursable at the fee schedule rate and does not apply to bundled or encounter rates.~~

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere (continued).

Effective for services on or after February 1, 2024~~4~~5, the Resource Based Relative Value Scale conversion factors are:

- Evaluation and Management services: ~~$25.40~~ $25.43
- Obstetric services: ~~$25.40~~ $25.43
- ~~Mental Health services: $27.50~~
- All other physician services: ~~$24.79~~ $25.04

Effective for services on or after April 15, 2014, procedure code 58565 pays the lower of:

1) Submitted charge; or
2) $1863.65

Effective July 1, 2007, through June 30, 2009, eligible providers are paid an additional $125 every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:

- Blood pressure less than 140/90; and
- Lipids less than 100; and

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere (continued).

- Patient is taking aspirin if over age 40; and
- Patient is not using tobacco; and
- For diabetic only, Hemoglobin A1c levels at less than 8.

Each recipient must have had at least two prior office visits with the claiming provider within the six months before the submission of the claim for the additional payment. Eligible providers are physicians who demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. To qualify for the rate adjustment, providers must submit documentation of the provision of specific services and complete clinical results per recipient that meet the criteria for optimal diabetic and/or cardiovascular care. Effective July 1, 2009, the rate adjustment is $250 every six months when all of the above criteria are met.

~~With the exception noted below, for all other services the payment rate is the lower of:~~
~~(1) submitted charges; or~~
~~(2) (a) 75% of the 50th percentile of the charges submitted by all providers of the service (except for services provided by home health agencies, home and community based waiver services providers, IEP providers, dentists, and providers whose payment rate is based on a percentage of the physicians' payment rate) in the calendar year specified in legislation governing maximum payment rates; or~~

~~(b) State agency established rate.~~

~~Effective January 1, 2000, the rate is increased by three percent.~~

~~Effective July 1, 2007, evaluation and management services" that are not "office and other outpatient services", "critical care services", or "preventive medicine new and established patient" services are paid the lower of the submitted charge or 23.7% over the rates in effect on January 1, 2006, when provided by: Steve~~

~~1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;~~
~~2) community mental health centers described in Attachment 3.1-A and 3.1-B at item 6.d.A; or~~
~~3) essential community providers as designated under Minnesota Statutes §62Q.19, in mental health clinics and centers certified under Minnesota Rules, parts 9520.0750 to 9520.0870,~~

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere (continued).

~~or hospital outpatient psychiatric departments.~~

~~The rate reductions affecting services rendered on or after July 1, 2009, do **not** apply to family planning services.~~

~~Effective for services provided on or after July 1, 2007, family planning services provided by family planning clinics, public health clinics and community health clinics are paid 25% over the rate in effect on June 30, 2007.~~

~~The rate reductions affecting services rendered on or after July 1, 2009, do **not** apply to the performance payments described in the following two paragraphs.~~

~~Effective July 1, 2007, through June 30, 2009, eligible providers are paid an additional $125 every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:~~

- ~~Blood pressure less than 130/80; and~~
- ~~Lipids less than 100; and~~
- ~~Patient is taking aspirin daily if over age 40; and~~
- ~~Patient is not using tobacco; and~~
- ~~For diabetic only, Hemoglobin A1c levels at less than 8.~~

~~Each recipient must have had at least two prior office visits with the claiming provider within the six months before the submission of the cla for the additional payment. Eligible providers are physicians who demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. To qualify for the rate adjustment, providers must submit documentation of the provision of specific services and complete clinical results per recipient that meet the criteria of optimal diabetic an/or cardiovascular care. Effective July 1, 2009, the rate adjustment is $250 every six months when all of the above criteria are met.~~

~~Effective July 1, 2007, the State agency established rate is increased five percent for physical therapy services, occupational therapy services, speech-language therapy services, and respiratory therapy services.~~

~~Effective July 1, 2010, payment rates for physical therapy services, occupational therapy services, and speech-language therapy services rendered on or after July 1, 2010, are increased by two percent.~~

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere (continued).

~~Effective July 1, 1998, the rate is increased three percent for these services; effective January 1, 2000, the rate is increased another three percent; effective October 1, 2005, and October 1, 2006, the rate is increased by 2.2553 percent, excluding respiratory therapy services. Effective October 1, 2007, the rate is increased by two percent, excluding respiratory therapy services. Effective October 1, 2008, the rate is increased by two percent, excluding respiratory therapy services.~~

~~The rates for respiratory therapy services are as follows:~~

~~Procedure Code~~	~~Rate~~
~~94640~~	~~$15.02~~
~~94642~~	~~19.02~~
~~94650~~	~~16.70~~
~~94651~~	~~14.48~~
~~94652~~	~~140.34~~
~~94656~~	~~100.24~~
~~94657~~	~~43.43~~
~~94660~~	~~100.24~~
~~94664~~	~~18.78~~
~~94665~~	~~12.93~~
~~94667~~	~~16.19~~
~~94668~~	~~16.19~~

If the service is provided by an **enrolled physician assistant**, the service is paid the lower of:

1) submitted charge; or
2) 90% of the reference file allowable.

If the service is provided by a **physician extender**, the service is paid the lower of:

1) submitted charge; or
2) 65% of the reference file allowable, ~~except for psychology services that are provided by a non-enrolled mental health practitioner, in which case the service is paid the lower of the submitted charge or 50% of the reference file allowable~~.

~~The rate reductions affecting services rendered on or after July 1, 2009, do **not** apply to the psychology services rates described above.~~

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere (continued).

If the service is provided by a **community health worker,** the service is paid the lower of:

1) submitted charge; or

2) The Resource Based Relative Value Scale calculated rate

Effective January 1, 2025 ~~2012~~, ~~**psychotherapy services**~~ **psychiatric services** are paid the lower of:

(1) submitted charge; or

(2) (a) the Resource Based Relative Value Scale calculated rate that is equal to 83 percent of the Medicare Physician Fee Schedule; or

(b) State agency established rate, which can be found at https://mn.gov/dhs/partners-and-providers/policies-procedures/minnesota-health-care-programs/provider/billing/fee-schedule/mhcp.jsp.

Reductions for Master's prepared professionals in section 6.d. on page 16 and 16a of this attachment apply to these services.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of psychiatric services.

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere (continued).

~~If the service is provided by a non-enrolled mental health practitioner, the supervising enrolled provider is paid the lower of:~~

~~(1) submitted charge; or~~

~~(2) 50% of item (2)(a), or (2)(b), or 2(c) above, for psychotherapy services.~~

Provider travel time is paid the lower of the submitted charge or as specified in item 4.b.

Anesthesia services personally performed by the anesthesiologist are paid the lower of:

(1) submitted charge; or

(2) the product of the physician conversion factor ($18.00)multiplied by the sum of the relative base value units and time units (one time unit equals fifteen minutes).

Anesthesia services provided by the anesthesiologist medically directing (supervising) one to four certified registered nurse anesthetists, student registered nurse anesthetists, or anesthesia residents are paid the lower of:

(1) submitted charge; or

(1) (relative base value unit + time units*) x Medicare anesthesiologist conversion factor x 0.632

Anesthesia services provided by the anesthesiologist medically directing (supervising) five or more certified registered nurse anesthetists or anesthesia residents are paid the lower of:

(1) the submitted charge; or

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere (continued).

(2) the physician conversion factor multiplied by four.

*one time unit equals 15 minutes

The State has established a rate for the following:

Procedure Code	Rate
1 V5090	182.15
2 V5110	273.23
3 V5160	273.23
4 V5200	182.15
5 V5240	273.23
6 V5241	182.15

~~Medical Assistance provides for an additional annual payment to teaching sites providing physician services, including mental health~~

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere (continued).

Psychiatric consultations ~~provided on or after April 1, 2012,~~ are paid through separate rates for the primary care ~~physician~~ and the psychiatric~~st's~~ components of the consultation.

Medical Assistance will pay for this service at the lower of:
(1) the submitted charge; or

(2) (a) Primary care component ~~is provided by a physician~~:

- CPT code 99499 HE AG facility component $24.39
- CPT code 99499 HE AG non-facility component $35.77

(b) Psychiatric consultation component ~~provided by a psychiatrist~~:

- 99499 HE AM Facility component $51.03
- 99499 HE AM Non-facility component $67.91

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere (continued).

In-reach care coordination services shall be paid the lower of:

- Submitted charge; or
- $9.54 per 15 minute unit

Community paramedic services shall be paid the lower of:

- Submitted charge; or
- $15.00 per 15 minute unit

Community emergency medical technician services shall be paid the lower of:

- Submitted charge; or
- $9.75 per 15 minute unit

Effective July 1, 2010, one one-month payment per recipient with 1-3 major chronic conditions receiving Group 1 health care home services, is the lower of:

- Submitted charge; or
- $10.14

Effective July 1, 2010, one one-month payment per recipient with 4-6 major chronic conditions receiving Group 2 health care home services, is the lower of:

- Submitted charge; or
- $20.27

Effective July 1, 2010, one one-month payment per recipient with 7-9 major chronic conditions receiving Group 3 health care home services is the lower of:

- Submitted charge; or
- $40.54

Effective July 1, 2010, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:

- Submitted charge; or
- $60.81

For each of the Groups 1-4 above, the payment rates listed will be increased by 15% if either of the following apply to the recipient:

- The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere (continued).

- health care; or
- The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.

~~Additional p~~Payment adjustment for physician practice groups at Hennepin County Medical Center, University of Minnesota Medical Center, and Regions Hospital. ~~Effective for services delivered on or after July 1, 2009, in recognition of the services provided by physicians and, effective for services delivered on or after January 1, 2011, non-physician practitioners affiliated with the two largest safety net hospitals, an additional adjustment, in total for the physician practice groups associated with Hennepin County Medical Center (Hennepin Healthcare System)and with Regions Hospital (HealthPartners), will be made in October of each calendar year, within two years following the close of the federal fiscal year, that equals the difference between average commercial payer rates for the hospital-based services delivered by physicians and practitioners affiliated with Hennepin County Medical Center and Regions Hospital and the rates paid to those physicians and practitioners under this section of Attachment 4.19-B using rates from the most recently complete calendar year available. Anesthesia services delivered on or after January 1, 2014, will also be included in the supplemental payment. Bundled radiology services are excluded from this payment. Total payments shall be based on data and calculated beginning in January of each year as follows:~~

Effective for services delivered on or after July 1, 2009, a payment adjustment for services provided in a calendar year will be made in the second quarter of each calendar year, within two years following the end of the base year. The base year is the calendar year ending two years prior to the year the payment is made. The payment adjustment equals the difference between the average commercial payer rates for the hospital-based services delivered by physicians, and other practitioners described below, affiliated with Hennepin County Medical Center and Regions Hospital, and the rates paid to those physicians and practitioners under this section of Attachment 4.19-B during the base year. Effective for services delivered on or after July 1, 2017, an additional payment adjustment shall be made for the hospital-based services delivered by physicians, and other practitioners described below, affiliated with the University of Minnesota Medical Center Fairview.

Total payments shall be calculated each year as follows:

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere (continued).

1. For physician services delivered at Hennepin County Medical Center by physicians and practitioners practicing with Hennepin Healthcare System, and for services delivered at University of Minnesota Medical Center Fairview by physicians and practitioners practicing with University of Minnesota Physicians, the set of services (by HCPCS code) delivered to Medicaid eligible individuals and billed on a fee-for-service basis shall be determined using MMIS data.

   For physician services delivered at Regions Hospital by physicians and practitioners practicing with HealthPartners, the set of services (by HCPCS code) delivered to Medicaid eligible individuals and billed on a fee-for-service basis shall be determined using a list of transaction control numbers from HealthPartners' billing system. DHS will use the supplied transaction control numbers to extract the relevant HCPCS codes from the MMIS system.

2. The payment rate for HCPCS code will be supplied, by the practice groups, for the top five commercial payers from the billing systems of the ~~two~~ physician practice groups.

3. The payment rates for each HCPCS code for each of the commercial payers will be averaged to determine the average commercial payer rate for each HCPCS code.

4. For each of the ~~two~~ physician practice group data sets, the average commercial payer rate is multiplied by the Medicaid frequency for the HCPCS codes for that physician practice group.

5. For each of the ~~two~~ physician practice group data sets, the Medicaid payment amount is subtracted from the result in paragraph 4 for each HCPCS code.

6. The final payment amount for each of the ~~two~~ physician practice groups is equal to the sum of the amounts in paragraph 5.

For purposes of this adjustment, services must be provided by physicians, nurse practitioners, nurse midwives, clinical nurse specialists, physician assistants, or certified registered nurse anesthetists.

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere. (continued)

Laboratory services are paid using the same methodology as item 3, Other lab and x-ray services.

The base rates as described in this item are adjusted by the following clauses of Supplement 2 of this Attachment:

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
D. MinnesotaCare Tax Rate Adjustment
E. Modifiers
F. Family Planning
G. Community and Public Health Clinics
H. Medicare Cap
I. Exceptions to payment methodology and reconstructing a rate
J. Copay converted to $3.00 provider rate reduction
P. Rate increase effective 07/01/07
R. Professional services decrease effective July 1, 2009.
S. Professional services decrease effective July 1, 2010
T. Rate increase July 1, 2010
~~V. Facility and professional services rate increase 2010~~
W. Physician and physician assistant rates are adjusted by the professional services rate decrease 2011
aa. Anesthesia service rates are adjusted by the miscellaneous services and material rate decrease 2011.
bb. Reimbursement for costs of services provided by a non-state, government-operated community mental health center
cc. Supplemental payment for medical education.
ff. Professional services rate increase effective September 1, 2014.

Other provider-preventable conditions are not eligible for payment as described in Attachment 4.19-A.

Reimbursement Template -Physician Services
Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☐ The rates reflect all Medicare site of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☐ The rates reflect all Medicare geographic/locality adjustments.

☒ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code:
Minnesota is using the Medicare fee schedule calculated using the "CMS PCP Enh Pmt Model Version1" tool developed by Deloitte. Rates were calculated using the tool on March 29, 2013. The rates do not include multiple locality adjustments because Medicare does not use multiple locality adjustments in this state. Minnesota will not adjust the fee schedule to account for any changes in Medicare rates throughout the year.

Minnesota calculated 2009 rates using the average payment to providers excluding any incentive, bonus, and performance based payments.

Minnesota calculated 2009 rates for services under the child and teen checkup program using the average payment to providers excluding any incentive, bonus, performance based, third party liability, and patient responsibility payments. We will compare this rate to the Medicare rate described above prior to any adjustment for third liability or patient responsibility payments when calculating FFP as described in 42 CFR § 447.415.

Method of Payment

☒ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☐ quarterly

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

99339, 99340, 99450, 99455

☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

99224 added January 1, 2011	99225 added January 1, 2011
99226 added January 1, 2011	99488 added January 1, 2013
99489 added January 1, 2013	99495 added January 1, 2013
99496 added January 1, 2013	

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☒ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

☐ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☐ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is:_____.

(Documentation of Vaccine Administration Rates in Effect 7/1/09 – continued)

☒ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: $8.50 for vaccines provided under the VFC program and $1.50 for all other vaccines.

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:

Effective Date of Payment

E & M Services

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014, but not prior to December 31, 2014. All rates are published at www. dhs.state.mn.us.

Vaccine Administration

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014, but not prior to December 31, 2014. All rates are published at www.dhs.state.mn.us.

5.a. Physician services (continued)

Recuperative Care Services

Recuperative care services are a model of care provided by enrolled recuperative care providers.

The recuperative care services include the following state plan benefits: nursing services described in item 6.d., intermittent or part-time nursing services under item 7.a., and physician services or rehabilitative services provided by community health workers under items 5.a. or 13.d.

Recuperative care is available for up to 60 days, subject to extensions that are prior approved by the Commissioner. Rates are based on direct service expenditures and physical plant costs based on the percentage of the facility devoted to treatment.

The per diem payment rate for services provided in the care plan and under physician orders is the lower of –
1) Submitted charges; or
2) $300 per day

Approved recuperative care settings may bill under this rate.

Not included in payment:

Physical plant costs of administrative or residential space
Room and board costs

Any provider delivering services through a per diem is paid through that per diem and cannot bill separately. Medicaid providers delivering services outside of the per diem must bill for those separate services in accordance with the state's billing procedures.

At least one of the services must by provided within the service payment unit for the provider to bill the per diem rate.

The state will annually monitor the actual provision of services paid under the per diem rate to ensure that beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and that rates remain in compliance with 1902(a)(30)(A) based on the actual provision of services.

5.b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Medical and surgical services furnished by a dentist are paid using the same methodology as item 5.a., Physicians' services.

6. Medical care or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

See items 6.a. through 6.d.

6.a. Podiatrists' services.

Podiatrists are paid using the same methodology as item 5.a., Physicians' services.

The base rate as referenced in this item is adjusted by the following clause of Supplement 2 of this Attachment:

W. Professional services rate decrease 2011.

6.b. Optometrists' services.

Optometrists are paid using the same methodology as item 5.a., Physicians' services.

The base rate as referenced in this item is adjusted by the following clause of Supplement 2 of this Attachment:

W. Professional services rate decrease 2011.

6.c. Chiropractors' services.

** This section intentionally left blank and has been deleted effective January 1, 2026

~~Chiropractors are paid using the same methodology as item 5.a., Physicians' services.~~

~~The base rates as described in this item are adjusted by the following clauses of Supplement 2 of this Attachment:~~

~~W. Professional services rate decrease 2011~~
~~cc. Supplemental payment for medical education~~

6.d. Other practitioners' services.

A. With the exception listed below, mental health services performed by a doctoral prepared mental health professional are paid the lower of:

(1) submitted charge; or

(2)(a) the Resource Based Relative Value Scale (RBRVS) calculated rate that is equal to 83 percent of the Medicare Physician Fee Schedule; or

(b) State agency established rate: or

(c) $65.01 per session for crisis assessment provided in a hospital outpatient department; or

(d) $37.80 per 60 minutes for cognitive remediation training.

Provider travel time is covered if a recipient's individual treatment plan requires the provision of mental health services outside the provider's normal place of business. Travel time is paid as a supplement to the payment for associated covered services. Travel time is paid at the lower of the submitted charge or 45 cents per minute.

The agency fee schedule rate was set as of June 28, 2011, and is effective for services provided on or after that date. All rates are published on the Minnesota Department of Human Service's public website (http://dhs.state.mn.us}.

Community health worker services are paid using the same methodology that applies to community health workers in item 5.a., Physicians' services.

6.d. Other practitioners' services. (continued)

Mental health services performed by a master's prepared mental health professional are paid the lower of:

1. submitted charge; or
2. 80% of the rate established for doctoral prepared mental health professionals.

Mental health services performed by a master's prepared mental health professional in a community mental health center are paid the lower of:

1. submitted charge; or
2. 100% of the rate established for doctoral prepared mental health professionals.

Mental health services provided by a mental health practitioner working as a clinical trainee as defined in Attachment 3.1-A, item 6.d.A., who is supervised by an enrolled provider are paid to the supervising enrolled provider at the lower of:

1. submitted charge; or
2. 100% of the rate established—for mental health professionals.

Adult day treatment services for mental illness provided on or after January 1, 2024 are paid the lower of:

1. submitted charge; or
2. $30.62 per 60 minutes.

On or after January 1, 2025, the rate for adult day treatment is annually adjusted according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Medicare Economic Index (MEI) as forecasted in the fourth quarter of the calendar year before the rate year.

Mental health services performed by a physician's assistant provided in an inpatient hospital are paid at the lower of:

1. Submitted charge; or
2. 80.4% of the base rate established for doctoral prepared mental health professionals.

In-reach care coordination services are paid using the same methodology that applies to in-reach care coordination services in item 5.a., Physicians' services.

Officer-involved, community-based care coordination provided on or after March 1, 2018, is paid at the lower of:

1. Submitted charge; or
2. $9.54 per 15 minutes.

6.d. Other practitioners' services. (continued)

The base rate as described in this item is adjusted by the following clauses of Supplement 2 of this Attachment.

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
D. MinnesotaCare Tax Rate Adjustment
E. Modifiers
G. Community and Public health Centers
I. Exceptions to payment methodology and reconstructing a rate
P. Rate Increase Effective July 1, 2007
T. Rate increase July 1, 2010
cc. Supplemental payment for medical education
ff. Professional services rate increase effective September 1, 2014

6.d. Other practitioners' services. (continued)

B. Effective for services provided on or after July 1, 1991, **public health nursing services** are paid the lower of:

1) submitted charge; or

2) State agency established rates based on comparable rates for services provided by a nurse practitioner in an office setting, or by a home health nurse in a home setting, or by a nurse providing perinatal services to women considered high-risk, ~~services~~ under item 20, Extended services to pregnant women.

Effective for services provided on or after July 1, 2008~~ 7/1/08~~, services provided by a community health worker, are paid using the same methodology that applies to community health workers in item 5.a., Physicians' services.

Effective for services provided on or after January 1, 2018, bundled services provided as part of an **evidence-based, home visit** are paid the lower of:
1) Submitted charge; or
2) $140 per visit.
Providers must provide services in accordance with the requirements of the model in order to receive payment.

The Department will periodically monitor the actual provision of services to ensure that beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and to ensure that the rates remain economic and efficient based on the services that are actually provided.

Public health nurses who administer pediatric vaccines as described in item 5.a., physicians' services, available through the Minnesota Vaccines for Children Program pursuant to §1928 of the Act, are paid for administering the vaccine using the same methodology described in item 5.a.

6.d. Other practitioners' services. (continued)

The base rate as described in this item is adjusted by the following clauses of Supplement 2 of this Attachment:

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
D. MinnesotaCare Tax Rate Adjustment
E. Modifiers
F. Family Planning
G. Community and Public Health Clinic
H. Medicare Cap
I. Exceptions to payment methodology and reconstructing a rate
J. Copay converted to $3.00 provider rate reduction
U. Facility services rate decrease 2009
aa. Miscellaneous services and materials rate decrease 2011
gg. Miscellaneous services and materials rate increase effective September 1, 2014

6.d. Other practitioners' services. (continued)

Payment for public health nurse assessments for personal care services is the lower of the submitted charge or the rate from the chart below.

Service	7/1/09	7/1/13	4/1/14	7/1/14	**7/1/15***
Initial Public Health Nursing Assessment Visit for Personal Care Services (in-person)	$260.91 /visit	$258.29 /visit	$260.87 /visit	$273.91 /visit	$276.65 /visit
Public Health Nursing Reassessment Visit for Personal Care Services submitted prior to the end date of current PCA service authorization	$260.91 /visit	$258.29 /visit	$260.87 /visit	$273.91 /visit	$276.65 /visit
Public Health Nursing Service Update submitted prior to the end date of current PCA service authorization	$130.46 /visit	$129.14 /visit	$130.43 /visit	$136.95 /visit	$138.32 /visit

* The Department will reduce payment by .5% for providers that fail to submit a quality improvement plan.

6.d.Other practitioners' services. (continued)

C. Acupuncture Services

Effective for services provided on or after January 1, 2012, ~~A~~acupuncture services are paid using the same methodology as item 5.a., Physicians' services.

6.d. Other practitioners' services. (continued)

D. **Administration of anesthesia by certified registered nurse anesthetists (CRNAs)** provided in an outpatient setting are paid the lower of:

(1) submitted charge; or

(2)(a) if the services are not provided under the medical direction of an anesthesiologist, effective July 1, 2009:

(relative base value units + time units*) x ($18.00); or

(b) if the services are provided under the medical direction of an anesthesiologist, effective July 1, 2009:

~~f~~(relative base value units + time units*) x Medicare CRNA conversion factor x 0.632

- Pursuant to ~~page 1~~ Supplement 2 of this Attachment, critical access hospitals are paid on a cost-based payment system for CRNA services based on the cost-finding methods and allowable costs of Medicare, if they apply and qualify for the CRNA direct billing exemption under Medicare Part B.

- Hospitals continue to be paid for CRNA services as part of the prospective payment system specified for inpatient hospital services in Attachment 4.19-A, unless CRNA services were not in the hospital's base rate. If CRNA services are not part of the hospitals' base rate, they are paid as specified in items (1) and (2), above.

Certified registered nurse anesthetist services that are not administration of anesthesia are paid as specified in item 5.a., Physicians' services.

* one time unit equals 15 minutes

6.d. Other practitioners' services. (continued)

E. Nurse Practitioner services

Effective July 1, 2007, through June 30, 2009, nurse practitioners and clinical nurse specialists are eligible for a supplemental payment of $125 every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:

- Blood pressure less than 140/90; and
- Lipids less than 100; and
- Patient is taking aspirin daily if over age 40; and
- Patient is not using tobacco; and
- For diabetic only, Hemoglobin A1c levels at less than 8.

Each recipient must have had at least two prior office visits with the claiming provider within the six months before the submission of the claim for the additional payment. Eligible providers are those nurse practitioners demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. To qualify for the rate adjustment, providers must submit documentation of the provision of specific services and complete clinical results per recipient that meet the above criteria for optimal diabetic and/or cardiovascular care. Effective July 1, 2009, the rate adjustment is $250 every six months when all of the above criteria are met.

~~E.~~**Nurse practitioner services** (independently enrolled) are paid the lower of:

1) submitted charge; or

2) 90% of the rate established for a physician providing the same procedure, using the same methodology as Item 5.a, Physicians' services.

~~Effective July 1, 2007, through June 30, 2009, providers are eligible for a supplemental payment of $125 every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:~~

- ~~Blood pressure less than 130/80; and~~
- ~~Lipids less than 100; and~~
- ~~Patient is taking aspirin daily if over age 40; and~~
- ~~Patient is not using tobacco; and~~
- ~~For diabetic only, Hemoglobin A1c levels at less than 8.~~

6.d. Other practitioners' services. (continued)

If the services are paid through the payment for inpatient services, the nurse practitioner cannot separately bill for payment.

Laboratory, radiology, immunization, injection and allergy services are paid using the same methodology set forth elsewhere in this Attachment. EPSDT invoices are paid using the same methodology as item 4.b., Early and periodic screening, diagnosis, and treatment services.

With the exception noted below, mental health services are paid using the same methodology as item, 6.d.A, Mental Health services.

Nurse practitioners who administer pediatric vaccines as described in item 5.a., physicians' services ~~2.a., Outpatient hospital services~~, available through the Minnesota Vaccines for Children Program pursuant to §1928 of the Act, are paid for administering the vaccine using the same methodology described in item ~~2~~5.a. ~~for these vaccines.~~

The base rate as described in this item is adjusted by the following clauses of Supplement 2 of this Attachment:

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
D. MinnesotaCare Tax Rate Adjustment
E. Modifiers
F. Family Planning
G. Community and Public Health Clinics
H. Medicare cap
I. Exceptions to payment methodology and reconstructing a rate
J. Copay converted to $3.00 provider rate reduction
P. Rate increase effective July 1, 2007
R. Professional services rate decrease 2009
S. Professional services rate decrease 2010
T. Rate increase effective July 1, 2010
W. Professional services rate decrease 2011

6.d. Other practitioners' services. (continued)

F. ~~**Phlebotomy and**~~ **Case management services** provided by the practitioners listed in Attachments 3.1-A/B, item 6.d.F. as a component of ~~the~~ receiving ~~Clozaril patient monitoring system~~ clozapine are paid the lower of:

(1) submitted charge; or

(2) ~~(a)~~ ~~for patient~~ the fee schedule allowed amount for separately billed monitoring, ~~and venipuncture in recipient's home or a single patient site, $38.57;~~ $20.60

~~(b) for patient monitoring when patient monitoring and venipuncture are performed in recipient's home for more than one patient, $20.60; or~~

~~(c) for patient monitoring performed in the physician's office, laboratory, clinic, or outpatient hospital, $20.60.~~

6.d. Other practitioners' services. (continued)

G. ~~**Health maintenance**~~ **Managed care organizations** are paid rates established by the State agency in consultation with an independent actuary and set by contract in accordance with 42 CFR ~~§447.361~~ §438.6(c).

6.d. Other practitioners' services. (continued)

H. Clinical nurse specialists
Effective July 1, 2007, through June 30, 2009, providers are eligible for a supplemental payment of $125 every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:

- Blood pressure less than 140/90; and
- Lipids less than 100; and
- Patient is taking aspirin daily if over age 40; and
- Patient is not using tobacco; and
- For diabetic only, Hemoglobin A1c levels at less than 8.

Each recipient must have had at least two prior office visits with the claiming provider within the six months before the submission of the claim for the additional payment. Eligible providers are those clinical nurse specialists who demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. To qualify for the rate adjustment, providers must submit documentation of the provision of specific services and complete clinical results per recipient that meet the above criteria for optimal diabetic and/or cardiovascular care. Effective July 1, 2009, the rate adjustment is $250 every six months when all of the above criteria are met.

~~H.~~ With the exception noted below, **clinical nurse specialist** services (independently enrolled) are paid the lower of:

1) submitted charge; or

2) 90% of the rate established for a physician providing the same procedure, using the same methodology as Item 5.a, Physicians' services.

~~Effective July 1, 2007, through June 30, 2009, providers are eligible for a supplemental payment of $125 every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:~~

- ~~Blood pressure less than 130/80; and~~
- ~~Lipids less than 100; and~~
- ~~Patient is taking aspirin daily if over age 40; and~~
- ~~Patient is not using tobacco; and~~
- ~~For diabetic only, Hemoglobin A1c levels at less than 8.~~

6.d. Other practitioners' services. (continued)

~~Each recipient must have had at least two prior office visits with the claiming provider within the six months before the submission of the claim for the additional payment. Eligible providers are those clinical nurse specialists who demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. To qualify for the rate adjustment, providers must submit documentation of the provision of specific services and complete clinical results per recipient that meet the above criteria for optimal diabetic and/or cardiovascular care. Effective July 1, 2009, the rate adjustment is $250 every six months when all of the above criteria are met.~~

~~With the exception noted below,~~ **Clinical nurse specialist** services (physician extenders) are paid the lower of:

1) submitted charge; or

2) 65% of the rate established for a physician providing the same procedure, using the same methodology as Item 5.a, Physicians' services.

Clinical nurse specialist services provided by a ~~**masters prepared nurse with American Nurses Association**~~ **certification as a clinical specialist in psychiatric or mental health** are paid as provided in item 6.d.A. ~~and as follows:~~

~~Effective July 1, 2007, evaluation and management services are paid the lower of the submitted charge or 23.7% over the applicable rate established above for independently enrolled or physician extender clinical nurse specialists.~~

~~Effective July 1, 2007, through June 30, 2009, providers are eligible for a supplemental payment of $125 every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:~~

- ~~Blood pressure less than 130/80; and~~
- ~~Lipids less than 100; and~~
- ~~Patient is taking aspirin daily if over age 40; and~~
- ~~Patient is not using tobacco; and~~
- ~~For diabetic only, Hemoglobin A1c levels at less than 8.~~

~~Each recipient must have had at least two prior office visits with the claiming provider within the six months before the submission of the claim for the additional payment. Eligible providers are those clinical nurse specialists who demonstrate the above optimal~~

6.d. Other practitioners' services. (continued)

Laboratory, radiology, immunization, injection and allergy services are paid using the same methodology set forth elsewhere in this Attachment. EPSDT invoices are paid using the same methodology as item 4.b., Early and periodic screening, diagnosis, and treatment services.

Clinical nurse specialists who administer pediatric vaccines as described in item 5.a., physicians' services, ~~2.a., Outpatient hospital services,~~ available through the Minnesota Vaccines for Children Program pursuant to §1928 of the Act, are paid for administering the vaccine using the same methodology described in item ~~2~~5.a. ~~for these vaccines~~.

The base rate as described in this item is adjusted by the following clauses of Supplement 2 of this Attachment:

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
D. MinnesotaCare Tax
E. Modifiers
F. Family Planning
G. Community and Public Health Centers
H. Medicare cap
I. Exceptions to payment methodology and reconstructing a rate
J. Copay converted to $3.00 provider rate reduction
P. Rate increase effective July 1, 2007
R. Professional services rate decrease 2009
S. Professional services rate decrease 2010
T. Rate increase effective July 1, 2010
W. Professional services rate decrease 2011

6.d. Other practitioners' services. (continued)

I. **Medication therapy management services.**

Medication therapy management services are paid the lower of submitted charges or:

A. for the first encounter, $52.00 for the first 15 minutes, then $24.00 for each additional 15-minute unit

1. for each provider a recipient visits, the first encounter is limited to one every 365 days

2. for each additional 15-minute unit, a maximum of four per encounter

B. for subsequent encounters, $34.00 for the first 15 minutes, then $24.00 for each additional 15-minute unit

1. for each subsequent encounter, a maximum of seven per recipient, every 365 days

2. for each additional 15-minute unit, a maximum of four per encounter.

The base rate as described in this item is adjusted by the following clauses of Supplement 2 of this Attachment:
A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
I. Exceptions to payment methodology and reconstructing a rate
R. Professional services rate decrease 2009
S. Professional services rate decrease 2010
W. Professional services rate decrease 2011

7. Home health services.

See items 7.a. through 7.d.

7.a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Payment for skilled nurse visits is the lower of the submitted charge or the rate from the chart below.

Service provided on or after	7/1/2013	4/1/2014	7/1/2014	7/1/2015	1/1/2022	1/1/2023	1/1/2024	1/1/2025
Skilled nurse visit	$70.04	$70.74	$74.28	$75.02	$80.86	$83.29	$98.72	$101.82

Immunizations and other injectables are paid using the same methodology as Item 2.a., Outpatient hospital services.

Home health agencies that administer pediatric vaccines in item 2.a., Outpatient hospital services, available through the Minnesota Vaccines for Children Program pursuant to §1928 of the Act, are paid using the same methodology in item 2.a. for these vaccines.

7.b. Home health aide services provided by a home health agency.

Payment for home health aide visits is the lower of the submitted charge or the rate from the chart below.

Service provided on or after	~~7/1/2013~~	4/1/2014	7/1/2014	7/1/2015	1/1/2022	1/1/2023	1/1/2024	1/1/2025
Home Health Aide Visit	~~$53.75~~	$54.29	$57.00	$57.57	$62.05	$63.91	$75.75	$78.13

7.c. Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place.

Notwithstanding the other payment methodologies outlined in this section 7.c., effective for services provided on or after July 1, 2019, medical supplies and equipment, and orthotics that are subject to the upper payment limit in accordance with section 1903 (i)(27) of the Social Security Act, are paid the lower of:

1. The submitted charge; or
2. The Medicare fee schedule amount without regard to any other allowable increases, including the MinnesotaCare tax.

Augmentative and alternative communication devices and pressure support ventilators are excluded from the above provision.

Hearing aids, eyeglasses and oxygen are purchased on a volume basis through competitive bidding in accordance with section 1915(a)(1)(B) ofthe Act and regulations at 42 C.F.R. § 431.54(d).

Medical supplies and equipment that are not purchased on a volume basisare paid the lower of:

1. submitted charge;
2. Medicare fee schedule amount for medical supplies and equipment;or
3. if Medicare has not established a payment amount for the medical supply or equipment, an amount determined using one of the following methodologies:
   (a) 50th percentile of the usual and customary charges submitted for the previous ~~two~~ calendar year mi~~n~~us 20 percent, plus current calendar year Medicare inflation factors for the medical supply or equipment;
   (b) if no information about usual and customary charges exists, payment is based upon the manufacturer's suggested retail price minus 20 percent; or
   (c) if no information exists about manufacturer's suggested retail price, payment is based on cost (wholesale) plus 20 percent.

Effective for services delivered on or after July 1, 2023, enteral nutrition and supplies must be paid:

1. If sufficient data exists for a product or supply, payment must be based upon the 50th percentile of the usual and customary charges per product code submitted to the commissioner, using only charges submitted per unit.

2. Data are sufficient if:
   (1) the commissioner has at least 100 paid claim lines by at least ten different providers for a given product or supply; or
   (2) in the absence of the data in subparagraph (1), the commissioner has at least 20 claim lines from at least five different providers for a product or supply that does not meet the requirements of subparagraph (1). Paid claim lines include the providers charge.
   (3) in the absence of the data in subparagraph (2), it will revert back to the June 30, 2023 rate.

7.c. Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place (continued).

3. Increases in rates resulting from the 50th percentile payment method must not exceed 150 percent of the previous fiscal year's rate per code and product combination.

4. If sufficient data are not available to calculate the 50th percentile for enteral products or supplies, the payment rate must be the payment rate in effect on June 30, 2023 or the 50th percentile rate that was previously set for those products or supplies.

For dates of service on or after July 1, 2024~~4~~5, enteral nutrition and supplies must be paid according to this paragraph and updated annually each January 1.

1. If sufficient data exists for a product or supply, payment must be based upon the 50th percentile of the usual and customary charges per product code submitted to the commissioner, for the previous calendar year, using only charges submitted per unit.

2. Data are sufficient if:
   (1) the commissioner has at least 100 paid claim lines by at least ten different providers for a given product or supply; or
   (2) in the absence of the data in subparagraph (1), the commissioner has at least 20 claim lines from at least five different providers for a product or supply that does not meet the requirements of subparagraph (1).

3. Increases in rates resulting from the 50th percentile payment method must not exceed 150 percent of the previous fiscal year's rate per code and product combination.

4. If sufficient data are not available to calculate the 50th percentile for enteral products or supplies, the payment must be:
   (1) The manufacturer's suggested retail price of that product or supply minus 20 percent.
   (2) If the manufacturer's suggested retail price is not available, payment must be the actual acquisition cost of that product or supply plus 20 percent.

7.c. Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place(continued).

Effective for services provided on or after October 1, 2021, enteral nutrition and supplies, customized and other specialized tracheostomy tubes and supplies, and durable medical equipment repair and service are paid the lower of:

1. The submitted charge, or
2. manufacturer's suggested retail price minus 20 percent; or
3. if manufacturer's suggested retail price is not available; manufacturer's invoice charge plus 20 percent

Effective for services provided on or after July 1, 2017, pressure support ventilators are paid at the lower of:

1. The submitted charge, or
2. The Medicare fee schedule rate plus 47 percent.

Effective for service on or after January 1, 2014, blood glucose meters and diabetic testing strips are paid at the lower of

1. submitted charge, and
2. the methodology described in Item 12.a.

In addition, the state agency will receive a rebate for preferred blood glucose meters and test strips in accordance with the manufacturer's contract with the state.

Effective September 1, 2011, augmentative and alternative communication device manufacturers and vendors must be paid the lower of the:

(1) submitted charge; or
(2) manufacturer's suggested retail price minus 20 percent for providers that are manufacturers of augmentative and alternative communication systems; or
(3) manufacturer's invoice charge plus 20 percent for providers that are not manufacturers of augmentative and alternative communication systems.

Effective July 1, 2025, phototherapy services provided to newborns in the home setting must include a service fee in the amount of $520 per patient per episode, in addition to the daily rental rate for the medical equipment. An annual inflation adjustment for the phototherapy service fee will be paid. The index for the inflation adjustment must be based on the Consumer Price Index for All Urban Consumers increase published by the Bureau of Labor Statistics. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of phototherapy services. The fee schedule rate was set as of July 1, 2025 and is effective for services provided on or after that date. All rates are published on the agency's website: https://mn.gov/dhs/partners-and-providers/policies-procedures/minnesota-health-care-programs/provider/billing/fee-schedule/mhcp.jsp

7.c. Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place(continued).

Effective for services provided on or after October 1, 2011, home infusion therapy services provided by home infusion pharmacies are paid the lower of:

(1) the submitted charge; or

(2) a per diem amount for home infusion therapy services as defined in home infusion HCPCS codes. The per diem rate is equal to the combined payment rates for the component services which include, but are not limited to, medical supplies and equipment, professional pharmacy services, care coordination, delivery and shipping and products used in a standard total parental nutrition formula.

No dispensing fee is paid for home infusion therapies when dispensed by home infusion pharmacies.

The base rates as described above in this item, are adjusted by the following clauses of Supplement 2 of this Attachment:

U. Facility services rate decrease 2009.
aa. Miscellaneous services and materials rate decrease 2011.
ee. Rate decrease effective July 1, 2014.
gg. Miscellaneous services and materials rate increase effective September 1, 2014.
hh. Rate increase effective July 1, 2015.
jj. Rate increase for miscellaneous services, effective July 1, 2015.

7.d. Physical therapy, occupational therapy or speech pathology and audiology services provided by a home health or medical rehabilitation agency.

Payment for therapy visits is the lower of the submitted charge or the rate from the chart below.

Service provided on or after	~~7/1/2013~~	4/1/2014	7/1/2014	7/1/2015	1/1/2022	1/1/2023	1/1/2024	1/1/2025
Physical Therapy Visit (PT)	~~$65.71~~	$66.37	$69.69	$77.43	$83.45	$85.95	$101.87	$105.07
Physical Therapy Visit (Ass't)	~~$42.71~~	$43.14	$45.30	$50.33	$54.25	$55.88	$66.23	$68.31
Speech Therapy Visit	~~$66.71~~	$67.38	$70.75	$78.60	$84.72	$87.26	$103.42	$106.67
Occupational Therapy Visit (OT)	~~$67.05~~	$67.72	$71.11	$79.00	$85.15	$87.70	$103.94	$107.20
Occupational Therapy Visit (Ass't)	~~$43.59~~	$44.03	$46.22	$51.35	$55.35	$57.01	$67.57	$69.69
Respiratory Therapy Visit	~~$46.44~~	$46.90	$49.25	$49.74	$53.61	$55.22	$65.45	$67.51

Physical therapy assistant and occupational therapy assistant services provided by a **home health agency** are paid using the same methodology as items 11a., Physical therapy and 11b., Occupational therapy.

7.d. Physical therapy, occupational therapy or speech pathology and audiology services provided by a home health or medical rehabilitation agency, continued.

~~Occupational Therapy Visit (OT)~~	~~$52.05/ visit~~	~~$54.13/ visit~~	~~$57.38/ visit~~	~~$59.10/ visit~~	~~$60.87 /visit~~	~~$65.35/ visit~~	~~$66.83~~	~~$68.17~~	~~$69.53~~	~~$67.74~~
~~Occupational Therapy Visit (Ass't.)~~				~~$38.42/ visit~~	~~$39.57 /visit~~	~~$42.49/ visit~~	~~$43.44~~	~~$44.31~~	~~$45.20~~	~~$44.08~~
~~Respiratory Therapy Visit~~	~~$37.85/ visit~~	~~$39.36/ visit~~	~~$41.72/ visit~~	~~$42.97/ visit~~	~~$44.26 /visit~~	~~$45.26/ visit~~	~~$46.28~~	~~$47.21~~	~~$48.15~~	~~$46.91~~

Services provided by **rehabilitation agencies** are paid using the same methodology as item 5.a, Physicians' services.

The base rate as described in this item is adjusted by the following clauses of Supplement 2 of this Attachment:

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
E. Modifiers
I. Exceptions to payment methodology and reconstructing a rate
L. Rehabilitation Agency rate increase

8. Private duty nursing services.

Payment for private duty nursing services is the lower of the submitted charge or the rate from the chart below.

Service provided on or after	7/1/2013	4/1/2014	7/1/2014	7/1/2015	1/1/2022	1/1/2023	1/1/2024
Private Duty Nursing L.P.N. Unit	$6.24	$6.30	$6.62	$6.69	$7.21	$7.43	$9.57
Private Duty R.N. Unit	$8.13	$8.21	$8.62	$8.71	$9.39	$9.67	$12.46
Private Duty L.P.N. (complex)	$7.32	$7.39	$7.76	$7.84	$8.45	$8.70	$11.21
Private Duty R.N. (complex)	$9.75	$9.85	$10.34	$10.44	$11.25	$11.59	$14.93

NOTE: 1 unit = 15 minutes

8. Private duty nursing services, continued.

Shared care: For two recipients sharing care, payment is one and one-half times the payment for serving one recipient. This paragraph applies only to situations in which both recipients are present and received shared care on the date for which the service is billed.

~~Effective March 1, 2006 and ending September 30, 2007, payment for private duty nursing services is increased by .2% for those providers who applied and met the competitive requirements for a medical assistance payment rate increase for the purpose of employee scholarships, except that the increase is .3% effective on or after September 1, 2006, for those providers who agree to accept the higher rate on a contract entered into on or after March 1, 2006 or whose new contract was entered into on or after September 1, 2006.~~

9. Clinic services

Clinic services are paid using the same methodology as item 5.a., Physicians' services, except:

dental services provided by clinics are paid using the same methodology as item 10, Dental services

end-stage renal disease hemodialysis provided by renal dialysis clinics is paid using the same methodology as item 2.a., Outpatient hospital services

~~As provided for in item 5.a., Medical Assistance provides for an additional annual payment for state fiscal year 2011 and thereafter, which includes a Department medical education payment for each state fiscal year to a sponsoring institution prior to April 30 of each year for the previous state fiscal year for distribution to Medical Assistance-enrolled physician and chiropractic clinics. In accordance with Code of Federal Regulations, title 42, section 447.321(b)(2), this payment will not exceed the Medicare upper payment and charge limits.~~

Freestanding ambulatory surgical centers:

Payment for facility services or facility component is the lower of:

(1) submitted charge; or

(2) (a) Medicare rates; or

(b) if there is not a Medicare rate, effective October 1, 1992, payment is at 105.6% of the 1990 average submitted charge; or

(c) if there is not a Medicare rate and there is not a 105.6% of the 1990 average submitted charge, effective October 1, 1992, payment is at the State agency established rate, which is derived by backing down the submitted charge to 1990 (by using the CPI) and increasing this amount by 5.6%.

9. Clinic services, continued.

The base rate as described in the item is adjusted by the following clauses of Supplement 2 of this Attachment:

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
D. MinnesotaCare Tax rate adjustment
E. Modifiers subject to an increase in base payment rate
U. Facility services decrease effective July 1, 2009
aa. Ambulatory surgery centers facility fees are adjusted by the miscellaneous services and materials rate decrease 2011.
cc. Supplemental payment for medical education
gg. Miscellaneous services and materials rate increase effective September 1, 2014.

10. Dental services.

A. Effective for services provided on or after October 1, 1992, ~~P~~payment is the lower of:

(1) submitted charge; or

(2)(a) 91.6% of the 50th percentile of the charges submitted by all dental service providers in the calendar year specified in legislation governing maximum payment rates. Effective July 1, 1997, this is increased by five percent, effective January 1, 1999, by three percent, and effective January 1, 2000, by three percent; or

(b) ~~State agency established rate~~if charge data does not exist, or if the above methodology would create an inequitable payment rate, the amount calculated by multiplying the provider charge by 91.6% and then multiplying by the CPI factor and the rate adjustments described above (charge x .916 x CPI x 1.05 x 1.03 x 1.03). The Department updates the CPI factor July 1 of each year by dividing the medical care services component of the CPI-U from the calendar year specified in legislation governing maximum payment rates (1989) by the medical care services component of the CPI-U from January of the current calendar year.

All posterior fillings are reimbursed at the amalgam rate, which follows the above methodology.

Effective for the following services provided on or after October 1, 1992, payment is the lower of the submitted charge or the state ~~The agency has~~ established rate~~s for the following services~~:

10. Dental services (continued):

Procedure Code	5/14/93	7/1/97	7/1/98	1/1/00
D5211	$294.50	$309.22	$318.49	$328.04
D5212	$342.00	$359.10	$369.87	$380.96

Procedure Code	6/1/94	7/1/97	7/1/98	1/1/00
D5510	$71.94	$75.53	$77.79	$80.12
D5520	$70.57	$74.09	$76.31	$78.59
D5610	$71.94	$75.53	$77.79	$80.12
D5620	$105.37	$110.63	$113.94	$117.35
D5630	$84.51	$88.73	$91.39	$94.13
D5640	$70.57	$74.09	$76.31	$78.59
D5650	$110.21	$115.72	$119.19	$122.76
D5660	$84.51	$88.73	$91.39	$94.13

Services provided on or after September 1, 2011, by an enrolled **dental therapist or advanced dental therapist** are paid using the same methodology as listed above.

~~A.~~B. Effective for services provided on or after October 1, 2010, services provided by State Operated Services shall be reimbursed on a reasonable cost basis.

INTERIM RATE METHODOLOGY
Interim payment rates will be equal to 150 percent of fee schedule rates. Interim payments shall be finalized to actual costs.

10. Dental services. (continued)

FINAL RATE METHODOLOGY
Costs will be determined using the "Medicaid Reimbursement Department of Human Services Medicaid Cost Report for State Operated Dental Clinics." This CMS-approved cost reporting protocol collects cost data from the State Operated Services dental providers and allocates the costs as allowable or unallowable using Medicare principles of reimbursement. The cost report also allocates allowable costs among payers using total billed charges.

Final payment rates will be equal to total costs multiplied by the result of Medicaid fee-for-service charges divided by total charges.

The Department will settle-up with State Operated Services dental providers within 18 months following the receipt of clean and correct cost data reported by the SOS dental providers for the rate year. If the interim payments exceeded the final rate, the Department will recover the overpayment within 60 days from determination of the final rate.

C. Critical access dental providers include public and private dental providers. The State agency established rate is the same for both public and private dental providers.

Effective for services on or after January 1, 2022 ~~July 1, 2016~~, payment to critical access dental providers not owned by a health maintenance organization, and who qualify under the criteria at Attachment 3.1-A or B, item 10.I.1-6, will be increased by 20% ~~37.5%~~ above the base payment rate described in Attachment 4.19-B, item 10(A).~~Payment to critical access dental providers owned by a health maintenance organization, and who qualify under the criteria at Attachment 3.1-A or B, item 10.I.1-6, will be increased by 35% above the base payment rate described in Attachment 4.19-B, item 10(A).~~

10. Dental services (continued):

X-ray services are paid according to the dental services methodology listed above. Effective January 1, 2002, payment for x-ray services provided to recipients under age 21 are paid the lower of:

1) the submitted charge; or
2) 85% of the median charges submitted in 1999.

Diagnostic examinations are paid according to the dental services methodology listed above. Effective January 1, 2002, payment for diagnostic examinations provided to recipients under age 21 are paid the lower of:

1) the submitted charge; or
2) 85% of the median charges submitted in 1999.

Effective for services provided on or after October 1, 1999, t**ooth sealants** and **fluoride treatments** are paid at the lower of:

1) submitted charge; or
2) 80% of the median charges submitted in 1997.

Effective January 1, 2000, the rate is increased by three percent.

Medical and surgical services (as defined by the Department) furnished by dentists are paid using the same methodology as item 5.a., Physicians' services.

Community health worker services educating patients to promote good oral health and self-management of dental conditions when supervised by a dentist are paid using the same methodology that applies to community health workers in item 5.a., Physicians' services.

The base rates as described in this item are adjusted by the following clauses of Supplement 2 of this Attachment:

cc. Supplemental payment for medical education
~~dd. Dental Services rate increase 2014~~
~~ii. Dental Services rate increase 2015~~
~~ll. Rate increase for dental services provided to children, effective July 1, 2017~~
mm. Dental Services rate increase 2022

10. Dental services (continued):

~~Additional p~~Payment adjustment for dental services provided at Hennepin County Medical Center and the University of Minnesota. Effective for services delivered on or after January 1, 2015, at Hennepin County Medical Center, and after July 1, 2017, at the University of Minnesota, an additional adjustment will be made for services provided in a calendar year in the second quarter of each calendar year, within two years following the end of the base year. The base year is the calendar year ending two years prior to the year the payment is made. The adjustment equals the difference between the average commercial payer rates for the dental services delivered by dentists and other dental practitioners affiliated with Hennepin County Medical Center, the University of Minnesota Medical Center Fairview, and the University of Minnesota School of Dentistry, and the rates paid to those dentists and dental practitioners under this section of Attachment 4.19-B during the base year. ~~in recognition of the dental services provided by dentists and other dental practitioners, an additional adjustment, in total for the dental practice groups contracted with Hennepin County Medical Center (Hennepin Healthcare System), will be made in the first quarter of each calendar year, within two years following the close of the federal fiscal year. The adjustment equals the difference between the average commercial payer rates for the services delivered at Hennepin County Medical Center by dentists and other dental practitioners affiliated with Hennepin County Medical Center and the rates paid to those providers under this section of Attachment 4.19-B using rates from the most recently complete calendar year available.~~ Total payments shall be ~~based on the data described below and~~ calculated ~~beginning with payments made in January of each year~~ as follows:

1. For dental services delivered at Hennepin County Medical Center by dentists dental hygienists, dental therapists, or advanced dental therapists ~~and other dental practitioners~~ practicing with Hennepin Healthcare System, the set of services (by relevant CPT and CDT code) delivered to Medicaid eligible individuals and billed on a fee-for-service basis shall be determined using MMIS data.

   For dental services delivered at the University of Minnesota Medical Center Fairview or the University of Minnesota School of Dentistry, by dentists dental hygienists, dental therapists, or advanced dental therapists practicing with University of Minnesota Physicians, the set of services (by relevant CPT and CDT code) delivered to Medicaid eligible individuals and billed on a fee-for-service basis shall be determined using MMIS data.

2. ~~Hennepin County Medical Center~~ The providers will supply, from ~~its~~ their billing systems, the payment rates for their top three commercial payers.

3. The payment rates for each CPT and CDT code for each of the commercial payers will be averaged to determine the average commercial payer rate for each code.

4. The average commercial payer rate is then multiplied by the Medicaid frequency for each code.

5. The Medicaid payment amount is subtracted from the result in paragraph 4 for each code.

6. The final payment amount is equal to the sum of the amount~~s~~ in paragraph 5.

11. Physical therapy and related services.

See items 11.a. through 11.c.

11.a. Physical therapy.

Physical therapy services are paid using the same methodology as item 5.a., Physicians' services.

Effective for services provided on or after January 1, 1997, physical therapy assistants are paid the lower of:

(1) submitted charge; or

(2) 100% of the fee schedule rate if the services are provided under the direction of the physical therapist who is on the premises; or

(3) 65% of the fee schedule rate if the services are provided when the physical therapist is not on the premises.

The base rates as described in this item are adjusted by the following clauses of Supplement 2 of this Attachment:

R. Professional services decrease effective July 1, 2009
V. Facility and professional services rate increase 2010.
aa. Miscellaneous services and materials rate decrease 2011.
ff. Professional services rate increase effective September 1, 2014.
jj. Rate increase for miscellaneous services, effective July 1, 2015

11.b. Occupational therapy.

Occupational therapy services are paid using the same methodology as item 5.a., Physicians' services.

Occupational therapy assistants are paid the lower of:

(1) submitted charge; or

(2) 100% of the fee schedule rate if the services are provided under the direction of the occupational therapist who is on the premises; or

(3) 65% of the fee schedule rate if the services are provided when the occupational therapist is not on the premises.

The base rates as described in this item are adjusted by the following clauses of Supplement 2 of this Attachment:

R. Professional services decrease effective July 1, 2009
V. Facility and professional services rate increase 2010.
aa. Miscellaneous services and materials rate decrease 2011.
bb. Reimbursement for costs of services provided by a non-state, government-operated community mental health center.
ff. Professional services rate increase effective September 1, 2014.
jj. Rate increase for miscellaneous services, effective July 1, 2015.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).

Speech, language, and hearing therapy services are paid using the same methodology as item 5.a., Physicians' services.

The base rates as described in this item are adjusted by the following clauses of Supplement 2 of this Attachment:

R. Professional services decrease effective July 1, 2009
V. Facility and professional services rate increase 2010.
W. Professional services rate decrease 2011.
ff. Professional services rate increase effective September 1, 2014.
jj. Rate increase for miscellaneous services, effective July 1, 2015.

12. Prescribed drugs, dentures, and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

See items 12.a. through 12.d.

12a. Prescribed Drugs

Payment is determined in accordance with 42 CFR §§447.512-518.

For drugs dispensed by a retail community pharmacy, long term care pharmacy, or other outpatient pharmacy, payment is the lower of:

1) the ~~estimated~~ actual acquisition costs of the drugs ~~or the maximum allowable cost set by the State agency,~~ plus a ~~fixed~~ professional dispensing fee; ~~or~~
2) the state-established maximum allowable cost, plus a professional dispensing fee; or
3) the provider's usual and customary charge to the general public.

~~The maximum allowable cost set by the State agency for multiple source drugs will not exceed, in the aggregate, the upper limits established under 42 CFR §447.512.~~

~~Effective September 1, 2011, t~~The State agency establishes the actual acquisition cost to equal the National Average Drug Acquisition Cost (NADAC). For multiple source drugs, the actual acquisition cost is the NADAC for the generic drug, but for multiple source drugs prescribed in accordance with 42 CFR § 447.512(c) the acquisition cost will be NADAC for the brand drug. ~~104% of the wholesale acquisition cost (wholesale acquisition cost plus four percent)for independently owned pharmacies located in a small rural or isolated rural Minnesota location, and 102% of the wholesale acquisition cost (wholesale acquisition cost plus two percent) for all other pharmacies. A pharmacy is considered independently owned if it is one of four or fewer stores under the same ownership nationally.~~

Drugs purchased through the Federal Supply Schedule and drugs purchased at nominal price are reimbursed at actual acquisition cost plus the professional dispensing fee. Nominal price means a price that is less than ten percent of average manufacturer price.

The state agency may establish a maximum allowable cost for drugs in instances where survey data indicates that pharmacies can purchase the drug at a price lower than NADAC or in instances that a NADAC price is not published. The maximum allowable cost shall reflect the acquisition cost of the drug, or for multiple source drugs, the acquisition cost of the generic drug except when prescribed in accordance with 42 C.F.R. § 447.512(c).

For drugs for which NADAC is not reported and the maximum allowable cost is not calculated, the agency establishes the actual acquisition cost to equal wholesale acquisition cost (WAC) minus two percent.

The Department will calculate the actual acquisition cost of multiple course source drugs in conformity with the upper payment limits established under 42 C.F.R. § 447.512.

The State agency establishes the acquisition cost of drugs acquired through the federal 340B drug pricing program at the 340B ceiling price.

For drugs administered in an outpatient setting, payment for prescription drugs is the lower of the provider's usual and customary charge to the general public, 106% of the average sales price, or the maximum allowable cost set by the State Agency. If the average sales price is not available, payment will be the lower of the provider's usual and customary charge to the general public, the wholesale acquisition cost, or the maximum allowable cost set by the State Agency. For drugs acquired through the federal 340B drug pricing program, payment is equal to 71.4% of the payment amount calculated using the methodology described in this paragraph.

The rate for specialty pharmacy products is the maximum allowable cost set by the State Agency plus a professional dispensing fee of ~~$10.77~~ $11.55 per prescription. The rate used is dependent upon the actual acquisition cost for the product. Specialty pharmacy products are those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens.

12a. Prescribed Drugs (continued):

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12a. Prescribed Drugs (continued):

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12a. Prescribed Drugs (continued):

With the following exceptions, the professional dispensing fee is ~~$10.77~~ $11.55 per prescription, for prescriptions filled using drugs that meet the definition of "covered outpatient drugs" according to 42 U.S.C. § 1396r-8(k)(2).

1) The professional dispensing fee for intravenous drugs that require mixing by the pharmacist is ~~$10.77~~ $11.55 per bag.

2) The professional dispensing fee for over-the-counter drugs is ~~$10.77~~ $11.55 for "outpatient prescription drugs" when dispensed in quantities equal to or greater than the manufacturer's package size. The dispensing fee is prorated based on the percent of the package dispensed when the pharmacy dispenses a quantity less than the manufacturer's package size.

3) The professional dispensing fee for prescribed over-the- counter drugs that are not "covered outpatient drugs" shall be $3.65. The dispensing fee is prorated based on the percent of the package dispensed when the pharmacy dispenses a quantity less than the manufacturer's package size.

In addition, the State agency will receive a rebate for prescribed drugs in accordance with the manufacturer's contract with the Centers for Medicare & Medicaid Services.

The base rates as described in this item are adjusted by the following paragraph(s) of Supplement 2:

cc. Supplemental payment for medical education
d. MinnesotaCare Tax Adjustment (ingredient cost only)

12.b. Dentures.

Dentures are paid using the same methodology as item 10, Dental services.

12.c. Prosthetic devices.

Payment is the lower of:

(1) submitted charge;

(2) Medicare fee schedule amount; or

(3) if Medicare has not established a payment amount for the prosthetic or orthotic device, an amount determined using one of the following methodologies:

(a) 50th percentile of the usual and customary charges submitted for the prosthetic or orthotic device for the previous calendar year minus 20 percent;

(b) if no information about usual and customary charges exists for the previous calendar year, payment is based upon the manufacturer's suggested retail price minus 20 percent; or

(c) if no information exists about the manufacturer's suggested retail price, payment is based upon the wholesale cost plus 20 percent.

The base rates as described in this item, except for those that apply to state operated dental clinics, are adjusted by the following clauses of Supplement 2 of this Attachment:

U. Facility services rate decrease 2009.
aa. Miscellaneous services and materials rate decrease 2011.
ee. Rate decrease effective July 1, 2014.
hh. Rate increase effective July 1, 2015.
jj. Rate increase for miscellaneous services, effective July 1, 2015.

12.d. Eyeglasses.

Effective March 2, 2010, payment for eyeglasses is based on volume purchase contracting established through the competitive bidding process.

For ophthalmic materials not covered by the volume purchase contract, is the lower of:

1) submitted charge; or

2) a).481 of the July 2001 Medicare rate; or
b) state agency established rate.

Ophthalmologists, optometrists and opticians are paid for dispensing eyeglasses using the same methodology as item 5.a, Physicians' services.

The base rate as described in this item for non-volume purchase contract materials is adjusted by the following clauses of Supplement 2 of this Attachment:

A. IHS/638 Facilities
C. TPL
D. MinnesotaCare Tax Rate Adjustment
E. Modifiers
H. Medicare Cap
I. Exceptions to payment methodology and reconstructing a rate
J. Copay converted to $3.00 provider rate reduction
U. Facility Services rate decrease 2009
aa. Eyeglass rates not subject to a volume purchase contract are adjusted by miscellaneous services and materials rate decrease 2011.
gg. Miscellaneous services and materials rate increase effective September 1, 2014.

13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than those provided elsewhere in the plan.

See items 13.a. through 13.d.

13.a. Diagnostic services.

Diagnostic services are paid using the same methodology as item 5.a., Physicians' services.

13.b. Screening services.

Screening services are paid using the same methodology as item 5.a., Physicians' services.

13.c. Preventive services.

Preventive services are paid using the same methodology as item 5.a., Physicians' services.

13.d. Rehabilitative services.

Rehabilitative services are paid using the same methodology in item 5.a., Physicians' services, except as listed below.

Physical therapy assistants are paid using the same methodology as item 11.a., Physical therapy.

Occupational therapy assistants are paid using the same methodology as item 11.b., Occupational therapy.

With the exceptions below, M**ental health services** are paid the lower of the submitted charge or the Resource Based Relative Value Scale calculated rate.

This rate includes mental health services provided by community mental health centers, except that ~~. For~~ partial hospitalization services provided by community mental health centers~~, the hourly rate is based on outpatient hospital charges for partial hospitalization.~~are paid using the methodology for partial hospitalization services provided by outpatient hospitals at Attachment 4.19-B, item 2.a.

13.d. Rehabilitative services. (continued)

Community health worker services are paid using the same methodology that applies to community health workers in item 5.a., Physicians' services.

Effective January 1, ~~2015~~2019, the following services provided as part of **Adult Rehabilitative Mental Health Services (ARMHS)** are paid as described below:

- A **functional assessment** is paid the lower of the submitted charge or ~~$20.61 per 15 minute unit~~$82.44 per session;

- Creation of an i**ndividualized treatment plan** is paid the lower of the submitted charge or ~~$20.61 per 15-minute unit~~$82.44 per session;

- **Basic living & social skills** provided by a mental health professional or practitioner are paid the lower of the submitted charge or $17.17 per 15-minute unit;

- **Basic living & social skills** provided by a mental health rehabilitation worker are paid the lower of the submitted charge or $12.87 per 15-minute unit;

- **Basic living & social skills** provided in a group setting, regardless of the provider, are paid the lower of the submitted charge or $7.55 per 15-minute unit. A "group" is defined as two to 10 recipients.

13.d. Rehabilitative services. (continued)

- **Community intervention** provided by a mental health professional or practitioner is paid the lower of the submitted charge or $48.68 per session;

- **Community intervention** provided by a mental health rehabilitation worker is paid the lower of the submitted charge or $36.51 per session;

- **Medication education** is paid the lower the submitted charge or $16.98 per 15 minute unit;

- **Medication education** provided in a group setting is paid the lower the submitted charge or $11.04 per 15 minute unit;

- **Level I certified peer specialist** services, are paid the lower of the submitted charge or $15.02 per 15 minute unit;

- **Level II certified peer specialist** services are paid the lower of the submitted charge or $17.17 per 15 minute unit;

- **Certified peer specialist** services in a group setting, are paid the lower of the submitted charge or $7.55 per 15 minute unit.

~~Effective October 1, 2008, **basic living and social skills** provided as part of mental health community support services are paid:~~

~~for mental health professionals or mental health practitioners, the lower of the submitted charge or $13.01 per 15 minute unit;~~

~~for mental health rehabilitation workers, the lower of the submitted charge or $9.75 per 15 minute unit; or~~

~~in a group setting, regardless of the provider, the lower of the submitted charge or $5.72 per 15 minute unit. For the purposes of mental health community support services, "group" is defined as two to 10 recipients.~~

~~Effective October 1, 2008, **consultation with significant people**, including relatives, guardians, friends, employers, and treatment providers, provided as part of mental health community support services is paid:~~

~~for mental health professionals or mental health practitioners, the lower of the submitted charge or $36.88 per session;~~

13.d. Rehabilitative services. (continued)

Crisis assessment, crisis intervention, and crisis stabilization provided as part of mental health crisis response services are paid:

- As described in item 4.b. when provided by mental health professionals or mental health practitioners;

- when provided by mental health rehabilitation workers, the lower of the submitted charge or $18.59 per 15- minute unit;

- in a group setting (which does not include short-term services provided in a supervised, licensed residential setting that is not an IMD), regardless of the provider, the lower of the submitted charge or $9.29 per 15-minute unit. For the purposes of mental health crisis response services, "group" is defined as two to 10 recipients;

For a supervised, licensed residential setting with four or fewer beds, and does not provide intensive residential treatment services, payment is based on a historical calculation of the average cost of providing the component services of crisis assessment, crisis intervention and crisis stabilization in a residential setting, exclusive of costs related to room and board or other unallowable facility costs, and is equal to the lower of the submitted charge or $642.86~~$523.10~~ per day.

13.d. Rehabilitative services. (continued)

The Department coordinates with county mental health staff to monitor the provision of crisis services via site reviews at re-licensure/certification, and when an allegation of improper billing or maltreatment is received. Provider data is compared to MMIS data to ensure adequate service provision;

- in a supervised, licensed residential setting, with five to sixteen beds, ~~that is not an IMD that provides short-term services, including intensive residentialrehabilitative mental health services, combining individual and group modalities and the individual provider's qualifications, and including consultation with significant people~~ the rate is the rate for residential rehabilitative services, below.

- When not provided in a supervised, licensed residential setting that is not an IMD that provides short-term services, **community intervention** ~~**consultation with significant people** including relatives, guardians, friends, employers, and treatment providers~~ provided ~~as part of mental health crisis response services~~ on or after October 1, 2008, as part of mental health crisis response services, ~~are~~ is paid:

  for mental health professionals or mental health practitioners, the lower of the submitted charge or $36.88 per session;

  for mental health rehabilitation workers, the lower of the submitted charge or $27.66 per session.

- Effective July 1, 2009, **Certified Peer Specialist** support provided as part of ~~mental health community support services or~~ mental health crisis response services are paid:

  for Certified Peer Specialists Level I, the lower of the submitted charge or $11.38 per 15 minute unit;

  for Certified Peer Specialists Level II (qualified at the mental health practitioner level), the lower of the submitted charge or $13.01 per 15 minute unit;

  in a group setting, the lower of the submitted charge or $5.72 per 15 minute unit.

13.d. Rehabilitative services (continued)

Effective October 1, 2010, dialectical behavior therapy services are paid:

for individual dialectical behavior therapy, the lower of the submitted charge or $40.00 per 15 minute unit;

for group dialectical behavior therapy skills training, the lower of the submitted charge or $18.16 per 15 minute unit.

Assertive community treatment (ACT) and **residential rehabilitative services (intensive residential treatment services and crisis stabilization)** providers are paid a per diem, per provider, rate determined by the Department inclusive of all ACT or residential rehabilitative services, staff travel time to provide ACT or residential rehabilitative services, and crisis stabilization services provided as a component of mental health crisis response services. Providers must submit a state-developed cost report annually. Reasonable costs of ACT and residential rehabilitative services are determined in accordance with Office of Management and Budget (OMB) Circular Number A-87 relating to for-profit entities, and OMB Circular Number A-122, relating to nonprofit entities. To determine the rate, the following statewide criteria are considered:

1. Direct service expenditures: direct service expenditures include employee costs associated with the program's direct service staff (salaries, training and fringe), service-related transportation, and contracted direct service staff costs. The Department calculates the direct services rate by dividing total direct service costs by the total units of service provided in the state fiscal year prior to the calendar year for which the rate is being determined.

   For new programs, programs converting to serve a different specific population, or programs changing capacity, estimated actual costs are used to determine the direct services rate.

2. Other program costs: other program costs consist of administrative and other non-direct services program costs. Such costs include, but are not limited to, administrative staff costs (salary and fringe), insurance, professional dues, and supplies. The Department calculates the other program costs rate by multiplying the direct services rate by a flat percentage. The percentage for ACT providers is 41%. The percentage for residential rehabilitation providers is 37%.

3. Physical plant costs: residential rehabilitation service providers receive additional reimbursement related to physical plant costs. Providers must designate the percentage of the facility that is entirely devoted to treatment and programming (e.g. individual treatment or therapy rooms and group treatment or therapy rooms).

13.d. Rehabilitative services (continued)

This does not include administrative or residential space. The Department calculates the physical plant costs rate by multiplying the total physical plant costs for the facility in the prior state fiscal year by the percentage of the facility devoted to treatment and programing. This amount is then divided by the total units of service from the prior state fiscal year.

The total per diem, per provider rate is the sum of the provider's direct services rate, other program costs rate, and physical plant costs rate (for residential rehabilitation service providers only). Effective for the rate years beginning on and after January 1, 2024, rates for ACT and IRTS must be annually adjusted for inflation using the Centers for Medicare and Medicaid Services Medicare Economic Index (MEI). 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. Rates are recalculated and put into effect January 1 of each year.

The state shall not claim FFP for any non-institutional service provided to individuals who are residents of facilities that meet the federal definition of an institution for mental diseases or a psychiatric residential treatment facility as described in federal regulations at 42 C.F.R. §§ 440.140, 440.160 and 42 C.F.R. § 441 Subparts C and D.

The Department coordinates with county mental health staff to monitor the provision of ACT and residential services via site reviews at re-licensure/certification, and when an allegation of improper billing or maltreatment is received. Provider data is compared to submitted cost reports and MMIS data to ensure adequate service provision and accurate cost reporting.

Assertive community treatment (ACT) services and **intensive residential treatment services** (IRTS) provided by county entities and entities furnishing specialized ACT or IRTS to a subpopulation of recipients are paid a per diem rate established by the Department based on the Department's consideration of the factors, above.

13.d. Rehabilitative services. (continued)

Assertive community treatment (ACT) services and **residential rehabilitative services** provided by IHS/638 facilities are paid according to the encounter rate specified on page 1 of this Attachment.

ACT services include case management services. Therefore, ACT services providers do not receive payment for the following case management services in the same month ACT services are provided, except for the first and last months of ACT services:

1. mental health targeted case management services under item 19.a.
2. relocation service coordination services under item 19.c.
3. case management services for persons not on a §1915(c) waiver who are vulnerable adults or adults with MR/RC under item 19.d.

Effective January 1, 2002, provider travel time is covered if a recipient's individual treatment plan requires the provision of mental health services outside of the provider's normal place of business. This does not include travel time included in other billable services.

Payment for **EPSDT rehabilitative services identified in IFSPs/IEPs** under the Individuals with Disabilities Education Act (IDEA) and provided by school districts to children with IFSPs/IEPs during the school day is pursuant to a cost-based, per child encounter rate. Each school district has separate per encounter rates for the EPSDT rehabilitative services listed in Attachments 3.1-A/B, item 13.d and for personal care assistant services in Attachments 3.1-A/B, item 4.b. Payment is made when there is an encounter by a Medical Assistance child for the service category. No more than one payment in each service category can be made per child, per day, by a school district.

INTERIM RATE METHODOLOGY EFFECTIVE OCTOBER 1, 2003

School districts are paid cost-based, interim, per child encounter rates using data collected for the prior two State fiscal years.

Interim Rate Formula: The interim rate formula is the same as the final rate formula effective October 1, 2003. At the start of the State fiscal year on July 1, the rate will be reviewed and updated annually, using the most current available data.

FINAL RATE METHODOLOGY EFFECTIVE OCTOBER 1, 2003

The Department will settle-up with school districts using actual data reported by school districts for the State fiscal year.

13.d. Rehabilitative services. (continued)

Final Rate Formula:

1. salaries and fringe benefits ÷ total employment hours

2. item 1 x direct medical assistance direct service hours

3. item 2 ÷ medical assistance encounters

4. item 3 x the cognizant agency's unrestricted indirect cost percentage for the school district

final rate = item 3 + item 4

Payment for chemical dependency treatment services ispursuant to statewide graduated rate and complexity standards, as reflected onthe following charts:

Chemical Dependency Rates-Adolescent Services Rates (Effective January 1, 2022~~1~~)

Adolescent Service Rates				Complexity	
Treatment Setting Descriptions	Addiction- only Basic Rate	1115 Waiver Base Rate	Co-occurring	~~Special~~ Populations~~s~~ Specific	Medical Services
Outpatient Treatment Rates					
Individual (one hour increments)	$72.11	~~$79.32~~ $86.53	+$6.49	~~+$4.32~~ $7.93	+$17.31
Group (one hour increments)	$35.03	~~$38.53~~ $42.04	+$3.15	~~+$2.08~~ $3.85	+$8.40
Residential Treatment Rates - acuity addressed in intensity					
High Intensity (Minimum 15 hours/week)	$216.34		+$12.98	~~+$6.49~~ $12.98	+$12.98
Hospital-Based Residential Per Diem Rates	$309.06		+$18.55	~~+$9.27~~ $24.72	

13.d. Rehabilitative services. (continued)

Substance Use Disorder ADULT Service Rates (Effective January 1, 2025~~5~~6)

Adult Service Rates				Complexity	
Treatment Setting Descriptions	Addiction Only Basic Rate	Co-occurring	Populations Specific	Civilly Committed	Medical Services
Assessment					
Comprehensive Assessment (per session)	$162.24				
Outpatient Treatment Rates					
Individual (one hour increments)	$86.53	+$6.49	$7.93		+$17.31
Group (one hour increments)	$42.04	+$3.15	$3.85		+$8.40
Treatment Coordination (per 15 minutes	~~$11.71~~ $37.13				
Peer Recovery Support (per 15 minutes)	$15.02				
Medication Assisted Therapy-Methadone-per diem	$16.07	+$1.20	$1.47		+$3.21
Medication Assisted Therapy-all other-per diem	$27.19	+$2.04	$2.49		+$5.44
Medication Assisted Therapy-Methadone-PLUS-per diem (minimum 9 hours counseling services per week)	$58.10	+$4.35	$5.33		+$11.63
Medication Assisted Therapy-all other-PLUS (same as above) per diem	$69.23	+$5.19	$6.35		+$13.85
Residential Treatment Rates - acuity addressed in intensity					
High Intensity (daily individual/group therapy)	~~$230.78~~ $294.67	~~+$10.76~~ $13.77	~~$14.34~~ $18.36	$151.50	~~+$10.76~~ $13.77
Low Intensity (Minimum 15 hours/week individual/group therapy)	$171.11	+$7.97	$10.63		+$11.96
Low Intensity (Minimum 5 hours/week individual/group therapy)	~~$82.24~~ $216.90	~~+$3.83~~ $10.11	~~$5.11~~ $13.49		~~+$11.49~~ $30.33
Hospital-Based Residential Per Diem Rates	$309.06	+$18.54	$24.72		
Withdrawal Management					
Clinically Managed(per diem)	$400				
Medically Monitored (per diem)	$515				

All programs maintain data documenting the nature and extent, or number of service units provided to each recipient. Programs remain eligible to bill for a client's intensity level when the client misses services, provided the program documents both the reason the client missed the service(s) and the interventions taken. Effective August 1, 2024, hours in a treatment week may be reduced in observance of federally recognized holidays. Room and board is not eligible for medical assistance payment as substance use disorder treatment.

13.d. Rehabilitative services. (continued)

Payment rates for **individual and group therapy services** are based on efficiency standards by which counseling-staff cost are at least 50% of all costs for providing both group and individual therapy. Reimbursement for any combination of individual and group therapy services in excess of 6 hours per day or 30 hours per week per beneficiary requires prior authorization.

Payment rates for **medication assisted therapy services** and **medication assisted therapy services plus additional counseling services** include the administration of methadone and other drugs in combination with counseling. Rates are based on standards of efficiency by which counseling staff costs are at least 50% of all service costs to provide the minimum number of treatment hours, to which the drug dosing cost is added. Medication assisted therapy services are generally provided daily, on an outpatient basis. For services provided in a residential setting, the daily residential rate is increased by the dosing cost.

Payment rates for **withdrawal management** are based on historical costs of direct and indirect services and account for variation in the intensity of the treatment and the required staffing levels.

The following adjustments to the base rates apply to outpatient services rendered by SUD providers certified by the Commissioner as meeting the standards of Minnesota's substance use disorder 1115 waiver demonstration. Providers eligible for this adjustment must offer Medication Assisted Treatment (MAT) services onsite or facilitate access to MAT services offsite and maintain formal referral arrangements with other demonstration providers offering step up and step down levels of care. Adjustments under this section are contingent on provider certification and Minnesota's continued participation in the federal demonstration waiver.

~~Payment is increased by 20 percent for outpatient SUD treatment services including individual and group therapy services in licensed adult and adolescent programs and medication assisted therapy in adult programs. Eligible providers~~ must have medical, psychological, laboratory, toxicology, and pharmacological ~~services available through consultation and referral in accordance with standards published by the Commissioner.~~

Payment for ASAM Level 1.0 is at the individual or group hourly rate. This level is for outpatient clients. Adults must receive up to eight hours per week of skilled treatment services and adolescents must receive up to five hours per week. Services provided by licensed programs must meet requirements in state law. Peer recovery and treatment coordination are provided beyond the hourly skilled treatment service hours allowable per week.

Payment for ASAM Level 2.1 is at the individual or group hourly rate. This level is for intensive outpatient clients. Adults must receive nine to 19 hours per week of skilled treatment services and adolescents must receive six or more hours per week. Peer recovery services and treatment coordination are provided beyond the hourly skilled treatment service hours allowable per week. Services provided by licensed programs must meet requirements in state law.

Payment for ASAM Level 2.5 (partial hospitalization, now known as High-intensity Outpatient)is at the individual and group hourly rate. For ASAM level 2.5, adults must receive 20 hours or more of skilled treatment services. Services provided by licensed programs must meet state law requirements. Level 2.5 is for clients who need daily monitoring in a structured setting, as directed by the individual treatment plan and in accordance with state law.

Payment for **ASAM level 3.1 clinically managed low-intensity residential services** is a daily per-diem rate based on an average of historical costs for this intensity. Programs must provide clients at least 5 hours per week of individual or group counseling services as directed by individual treatment plans. Programs providing clients at least 15 hours per week of individual or group counseling services as directed by individual treatment plans may use the corresponding 15 hour per week per-diem rate.

Payment for **ASAM level 3.3 clinically managed population specific high-intensity residential services** is a daily per-diem rate based on an average of historical costs for this intensity. Programs must be enrolled as a disability responsive program and specialize serving participants with traumatic brain injuries or other cognitive impairments. Programs must provide clients daily individual or group counseling services as directed by individual treatment plans.

Payment for **ASAM level 3.5 clinically managed high-intensity residential services** is a daily per-diem rate based on an average of historical costs for this intensity.

Programs must have a 24 hour staffing coverage and provide clients daily individual or group counseling services as directed by individual treatment plans. Payment rates for substance use disorder services provided in a hospital-based residential program are based on an averaging of historical rates for these programs.

Residential SUD providers must have medical, psychological, laboratory, toxicology, and pharmacological services available through consultation and referral in accordance with standards published by the Commissioner.

13.d. Rehabilitative services. (continued)

The following enhancement services for which additional payment rates apply, address client complexity and may be paid in addition to payment for the services that address client acuity described above:

Co-occurring services address both the client's identified substance use disorder and mental health issues, including standardized mental health screening and appropriate mental health diagnostic assessment, monthly multi-disciplinary case review, and family education addressing both disorders and the interaction between the two. Programs must meet state licensing requirements and program enrollment standards. The rate may be applied to either outpatient, or residential settings, and is based on the additional cost of mental health professionals.

~~**Special population services** are specifically designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background. Programs must meet state licensing requirements and program enrollment standards. The rate may be applied to either outpatient, or residential settings, and is based on the additional cost of program material translation, amending curriculum to address cultural perspectives, and staff training.~~

Civilly committed recipients present some of the most difficult and complex care needs. They receive high-intensity residential services, have been civilly committed to the care of the Commissioner, and are a potential threat to themselves or others. The rate is based on the increased costs for additional staff attention and monitoring.

Medical services include health care, nursing, dietary and emergency physician services that are documented as provided to clients. Programs must be able to meet adequate staffing standards of appropriately credentialed medical staff to assess and address the client's health care needs. The rate is based on additional costs for medical staff.

~~**The base rate as described in this item is adjusted by the following clauses of Supplement 2 of this Attachment:**~~

~~A. IHS/638 Facilities~~
~~B. Critical Access Hospitals~~
~~C. TPL~~
~~D. MinnesotaCare Tax Rate Adjustment~~
~~E. Modifiers~~
~~G. Community and Public health Clinics~~
~~I. Exceptions to payment methodology and reconstructing a rate~~
~~P. Rate Increase Effective July 1, 2007~~
~~T. Rate Increase July 1, 2010~~
~~bb. Reimbursement for costs of services provided by a non-state, government-operated community mental health center~~
~~cc. Supplemental payment for medical education~~

13.d. Rehabilitative services. (continued)

~~ff. Professional servies rate increase effective September 1,2014~~

The following enhancements for which additional payment rates apply are for programs specializing in population specific treatment. Providers will receive an enhanced payment for satisfying each of the population specific criteria described below.

Disability responsive program means a program that is designed to serve people with disabilities including individuals with traumatic brain injuries, developmental disabilities, cognitive disabilities, and physical disabilities. Disability responsive programs must employ people with the necessary professional training to serve individuals with the specific disabilities that the program is designed to serve. The rate is based on the additional cost of hiring qualified staff and for specific training activities.

Culturally specific or culturally responsive programs are designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background. Programs must be governed with significant input from individuals with the same background as the people receiving treatment. At least 50 percent of the employees providing treatment services must be members of the specific community served.

The base rate as described in this item is adjusted by the following clauses of Supplement 2 of this Attachment:

F. IHS/638 Facilities
G. Critical Access Hospitals
H. TPL
I. MinnesotaCare Tax Rate Adjustment
J. Modifiers
H. Community and Public health Clinics
I. Exceptions to payment methodology and reconstructing a rate
P. Rate Increase Effective July 1, 2007
T. Rate Increase July 1, 2010
bb. Reimbursement for costs of services provided by a non-state, government-operated community mental health center
cc. Supplemental payment for medical education
ff. Professional services rate increase effective September 1, 2014.

13.d. Rehabilitative Services. (continued)

Certified Community Behavioral Health Center Services

Certified Community Behavioral Health Center (CCBHC) services include a comprehensive and integrated package of mental health and substance use disorder treatment services and supports listed under the Rehabilitative Services benefit (§ 13.d.) in Attachments 3.1-A and 3.1-B.

The state reimburses CCBHC providers on a per visit basis using a provider-specific bundled daily payment rate. The bundled payment represents the daily cost of providing CCBHC services. A CCBHC provider receives payment for each day CCBHC services are provided to a Medicaid beneficiary. Payment is limited to one payment per day, per CCBHC, per beneficiary for each CCBHC visit. Visits eligible for reimbursement include days on which at least one CCBHC service is provided to a beneficiary.

CCBHC Rate Methodology

The payment rate for CCBHC services is based on the total annual allowable CCBHC costs divided by the total annual number of CCBHC visits. Allowable costs include the salaries and benefits of Medicaid providers, the cost of services provided under agreement, and other costs such as insurance or supplies needed to provide CCBHC services. Indirect costs include site and administrative costs associated with providing CCBHC services. For the purposes of calculating rates, visits include all visits for CCBHC services including both Medicaid and non-Medicaid visits. Allowable costs are identified using requirements in 45 CFR §75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards and 42 CFR §413 Principles of Reasonable Cost Reimbursement.

CCBHCs must provide data on costs and visits to the department annually using the CMS CCBHC cost report. Annual CCBHC cost reports based on audited financials are due to the State by May 15th. Upon receipt from the CCBHC, the cost reports are reviewed by a Certified Public Accounting firm. Upon acceptance of the CCBHC cost reports from the accounting firm, the state sets the rates for the following rate year. The rate year follows the calendar year.

13.d. Rehabilitative Services. (continued)

Initial Payment Rates

The payment rate for CCBHC services is based on the total annual allowable CCBHC costs divided by the total annual number of CCBHC visits. Allowable costs include the salaries and benefits of Medicaid providers, the cost of services provided under agreement, and other costs such as insurance or supplies needed to provide CCBHC services. Indirect costs include site and administrative costs associated with providing CCBHC services. For the purposes of calculating rates, visits include all visits for CCBHC services including both Medicaid and non-Medicaid visits. Allowable costs are identified using requirements in 45 CFR §75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards and 42 CFR §413 Principles of Reasonable Cost Reimbursement.

The state will establish a provider-specificbundled payment rate using audited historical cost report data adjusted for the expected cost of delivering CCBHC services. Estimates must include the expected cost of providing the full scope of CCBHC services and the expected number of visits for the rate period. The initial rates include expected costs and visits that are subject to review by a Certified Public Accounting firm and the state. The bundled daily rate is calculated by dividing the total annual allowable expected costs of CCBHC services by the total annual number of expected CCBHC Medicaid and non-Medicaid visits.

Initial payment rates for CCBHCs transitioning from the Section 223 Demonstration to the state plan will be the approved demonstration rates.

Rate Adjustments for Changes in Scope

CCBHC providers may request a rate adjustment for changes in scope expected to change individual CCBHC provider payment rates by 2.5 percent or more. The provider must submit information to the state regarding changes in the scope of services, including changes in the type, intensity, or duration of services, the expected cost of providing the new or modified services, and any projected increase or decrease in the number of visits resulting from the change. Projections are subject to review by a Certified Public Accounting firm and the state. Provider-specific rate adjustments for changes in scope are permitted once per year and take effect with annual rate updates.

13.d. Rehabilitative Services. (continued)

Rebasing and Inflation Adjustments

CCBHC payment rates are rebased after an initial rate period, following a rate adjustment for a change in scope, and ~~three~~ two years following the last rebasing. Rates are rebased by dividing the total annual allowable CCBHC costs from the CCBHC's most recent 12 month audited cost report by the total annual number of CCBHC Medicaid and non-Medicaid visits during that 12-month time period. The resulting rate is trended from the midpoint of the cost year to the midpoint of the rate year using the MEI.

Initial payment rates are rebased once the CCBHC submits the first audited cost report including a full year of actual cost and visit data for CCBHC services under the state plan. Rates are rebased using actual data on costs and visits. Rebased rates take effect the following January, and the state does not reconcile previous payments to cost.

Rates adjusted for a change in scope are rebased once the CCBHC submits the first cost report with a full year of cost and visit data including the change in scope. Rates are rebased using actual data on costs and visits Rebased rates take effect the following January, and the state does not reconcile previous payments to cost.

Payment rates are updated between rebasing years by trending each provider-specific rate by the Medicare Economic Index (MEI) for primary care services. Rates are trended from the midpoint of the previous calendar year to the midpoint of the following year using the MEI.

Incentive Payments

CCBHCs are eligible for a quality incentive payment based on reaching specific numeric thresholds on state identified performance metrics. Quality incentive payments are in addition to payments under the bundled payment rate and are paid to CCBHCs that achieve specific performance thresholds identified by the state agency with input from clinical expertsand stakeholders and may include measures specific to the population served in each clinic.

CCBHCs must achieve thresholds on all six (6) quality measures in order tobe eligible for a quality incentive payment. A minimum of 30 members/visits (i.e., denominator size) for each CCBHC must be present in order for the state to calculate any given measure. For measures with multiple reported rates, the minimum denominator size will need to be met for all rates calculated under the measure.

The measurement year aligns with the rate year. The state will publish quality measures and numeric thresholds and notify each CCBHC of the criteria for receiving incentive payments in writing prior to the start ofeach measurement year.

13.d. Rehabilitative Services. (continued)

CCBHCs will be notified of their performance on the required measures and the incentive payment amount by the 12th month following the measurement year. CCBHCs must provide the department with data needed to determine incentive payment eligibility within 6 months following the measurement year. CCBHCs must be certified and enrolled as CCBHC providers for the entire measurement year to be eligible for incentive payments.

Calculation of Quality Incentive Payments

Quality incentive payments are derived from a single pool of funds equal to 5% of all CCBHC payments made to providers during the measurement year.

CCBHCs meeting performance metric thresholds receive a lump sum quality incentive payment which is the sum of the following two factors:

1. Non-weighted share: The non-weighted share of a provider's quality incentive payment is calculated by taking the total quality incentive payment pool, multiplied by 25%, and divided by the total number of CCBHCs that were certified and enrolled as CCBHC providers for the entire measurement year.

2. Share weighted by volume: The weighted share of a provider's quality incentive payment is calculated by taking the total quality incentive payment pool multiplied by 75%, then multiplying that amount by the percentage of the total CCBHC visits attributable to that CCBHC that was certified and enrolled as a CCBHC provider for the entire measurement year.

The sum of 1 and 2 above represents the total incentive payment that is paid to a qualifying CCBHC if they meet the threshold for all six of the quality incentive measures. No incentive payments are made to CCBHCs who do not meet the threshold for all six of the quality incentive measures. The share of the pool which would have otherwise gone to CCBHCs that do not meet their thresholds is not reallocated or paid to those CCBHC providers that do meet their thresholds.

The State will make the incentive payments to qualifying CCBHCs after the 12th month following the measurement year.CCBHC providers converting from the Section 223 Demonstration Program to state plan authority are eligible for prorated incentive payments for the portion of the measurement year that services were provided under state plan authority. Payment under this paragraph is equal to the CCBHC's incentive payment for the year multiplied by the quotient of the number of months under state plan authority divided by 12. The state defined quality incentive performance measures, technical specifications, patient volume minimums, and thresholds are effective October 1, 2020 and are located at the Evaluation tab of this website: https://mn.gov/dhs/partners-and-providers/policies-procedures/adult-mental-health/ccbhc/

14. Services for individuals age 65 or older in institutions for mental diseases.

See items 14.a. through 14.c.

14.a. Inpatient hospital services.

See Attachment 4.19-A.

14.b. Nursing facility services.

See Attachment 4.19-D.

14.c. Intermediate care facility for the mentally retarded (ICF/MR) services.

See Attachment 4.19-D.

15. Nursing facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31) of the Act, to be in need of such care.

See items 15.a. and 15.b.

15.a. Nursing services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31) of the Act, to be in need of such care.

See Attachment 4.19-D.

15.b. Intermediate care facility services (other than such services in an institution for mental diseases) in a public institution (or distinct part thereof) for persons with mental retardation or related conditions.

See Attachment 4.19-D.

16. Inpatient psychiatric facilities services for individuals under 22 years of age:

Payment for services received by recipient residing in a hospital are described in ~~See~~ Attachment 4.19-A.

Payment for services received by recipient residing in a psychiatric residential treatment facility are described in Supplement 4 to Attachments 4.19-A.

17. Nurse -midwife services.

Nurse-midwife services are paid using the same methodology as item 5.a., Physicians' services.

The base rates as described in this item are adjusted by the following clauses of Supplement 2 of this Attachment:

W. Professional Services rate decrease 2011

18. Hospice care (in accordance with section 1905(o) of the Act).

Payment is determined using Medicaid rates published by CMS on an annual basis adjusted for regional differences in wages using the hospice wage index ~~basic payment rates for four levels of care~~ and payment for physician services. Additional payment of a room and board amount is made for nursing home residents.

As of January 1, 2016, hospice includes payment for two periods of routine home care and an additional service intensity add-on payment. The fixed daily rates for the following ~~four~~ levels of care are determined by CMS using the Medicare payment methodology except that no copayments are deducted.

(1) Routine Home Care ~~Day~~ (days 1 – 60)
(2) Routine Home Care (days 61 and later)
(3) Continuous Home Care Day
(4) Inpatient Respite Day
(5) General Inpatient Day
(6) Service intensity add-on

~~The current CMS Medicaid hospice rates are used for rate determinations, which are based on Medicare and are updated annually. The State pays the CMS location-adjusted Medicaid amount.~~

The fixed daily rates are designed to pay the hospice for the costs of all covered services related to the treatment of a recipient's terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made by the hospice.

Payment for room and board for hospice patients residing in long term care facilities is based on 95% of the case mix rate determined in accordance with the Medicaid payment methodology contained in Attachment 4.19-D. Payment is made to the hospice provider.

Payment for physician services not included in the fixed daily rate is based on the usual Medicaid payment methodology for physician services contained elsewhere in this Attachment. If the attending physician is an employee of the hospice or is providing services by arrangement with the hospice, the hospice is paid for the physician services. If the attending physician is not a hospice employee, payment is made directly to the physician provider in accordance with the usual Medicaid payment methodology for physician services contained elsewhere in this Attachment.

The limits and cap amounts are the same as used in the Medicare Program except that the inpatient day limit on both inpatient respite care days and general inpatient care days does not apply to recipients afflicted with acquired immunodeficiency syndrome (AIDS).

The base rates as described in this item are adjusted by paragraph gg. of Supplement 2 entitled, Miscellaneous services and materials rate increase effective September 1, 2014.

19. · Case management services as defined in, and to the groups specified in, Supplements 1 through ~~1e~~ 1d to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

See items 19.a. through ~~19.d~~ 19.e.

· Special TB-related services under Section 1902(z)(2)(F) of the Act.

Payment for direct observation of the intake of prescribed drugs by outpatient recipients is paid using the same methodology as item 6.d.B., Public health nursing services.

19.a. Mental health targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

Payment is made on a monthly basis. Costs associated with mentoring, supervision and continuing education may be included in the monthly rate. Payment is limited to the components listed in Supplement 1 to Attachments 3.1-A/B, "Definition of Services."

1. The monthly rate for mental health targeted case management services provided by ~~state or~~ county staff is based on an aggregate of time spent performing all elements of case management services. There are separate rates for adults and children.
2. The rate for mental health targeted cases management services provided by a facility of the Indian Health Service (IHS) or by a 638 facility is made according to the encounter rate specified on page 1 of this Attachment.
3. The rate for mental health targeted case management services provided by entities under contract with a ~~county, a~~ facility of the IHS~~,~~ or a 638 facility is based on the monthly rate negotiated by ~~the county,~~ the IHS facility or the 638 facility. The negotiated rate must not exceed the rate charged by the entity for the same service to other payers.
4. The rate for mental health targeted case management services provided by entities under contract with a county is based on a standard caseload size derived from the estimated average number of hours that case management staff spend on recipients each month. Counties may request an adjustment to the standard caseload size and may request an additional adjustment for costs associated with the provision of culturally specific services.

~~a) If the service is provided by a team of contracted vendors, the county, the IHS facility or the 638 facility may negotiate a team rate with a vendor who is a member of the team. The team must determine how to distribute the rate among its members. No payment received contracted vendors will be returned to the county or the IHS facility, or the 638 facility, except to pay the county, the IHS facility or the 638 facility for advance funding provided by the county, IHS facility or the 638 facility to the vendor.~~

19.a. Mental health targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

~~b)~~ If the service is provided by a team that includes contracted vendors, IHS or 638 facility staff, and state or county staff, the costs for the state or county staff participation in the team must be included in the rate for county-provided services. In this case, the contracted vendor, the IHS or 638 facility 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 client's file, the need for team mental health targeted case management and a description of the roles of team members.

~~**Rate methodology for County and State Staff: July 1, 2000 through June 30, 2003**~~

~~Beginning July 1, 2000, a statistically valid random moment time study, Minnesota's Social Services Time Study (SSTS), is used to construct a monthly for mental health targeted case management services. The SSTS separates time of all direct services staff into a number of categories that constitute allowable mental health targeted case management activities and other unallowable activities. The proportion of allowable to total activities, when multiplied by the overall provider costs establishes the costs of mental health targeted case management activity.~~

~~The percentage of time spent by services staff on allowable mental health targeted case management services for children and adults is applied to the annual costs of providing social services and divided by twelve to arrive at the eligible cost per month. These figures are divided by the average number of children and adults who received mental health targeted case management services per month. The result is two separate, monthly payment rates for mental health targeted case management, one for children and one for adults.~~

19.a. Mental health targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

~~The two rates represent one month's work of eligible mental health targeted case management activity. Only one claim per client is allowed per calendar month for mental health targeted case management services provided county and state staff. The rate is the same for medical assistance-eligible and non-medical assistance eligible clients. All of the following conditions must be met in order for a claim to be made:~~

- ~~the client must be eligible for medical assistance;~~
- ~~the client received mental health targeted case management services in that month; and~~
- ~~all documentation requirements are met.~~

~~The rate is reviewed and updated annually, using the most current, available data.~~

~~**Rate Formula:**~~

~~**CP** = Average monthly social services cost pool for the most recent year for that class of providers~~

~~**P** = Percentage of eligible mental health targeted case management time as identified on the most recent year of the SSTS for that class of providers~~

~~**N** = Monthly average number of clients receiving mental health targeted case management services for that class for providers using the most recent year's work of data~~

~~**(CP x P)** = Monthly costs of proving mental health targeted case management services for that class of providers~~

~~**(CP x P)/N** = Mental health targeted case management monthly rate for that class of providers~~

19.a. Mental health targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

Rate Methodology for Services Provided by County ~~and State~~ Staff: ~~July 1, 2003~~

The Minnesota Social Services Time Study (SSTS) is used to construct a monthly rate for: (1) mental health targeted case management services for children; and (2)(a) mental health targeted case management services for adults and (b) targeted case management services for the group specified in Supplement 1c to Attachments 3.1-A/B. The SSTS separates time of all direct services staff into a number of categories that constitute: (1) allowable mental health targeted case management activities for children; (2) allowable mental health targeted case management activities for adults and allowable targeted case management activities for the group specified in Supplement 1c; and (3) other, unallowable activities.

The proportion of allowable to total activities, when multiplied by the overall provider cost, establishes the costs of: (1) mental health targeted case management activity for children; and (2) mental health targeted case management activity for the adults and targeted case management activity for the group specified in Supplement 1c.

The percentage of time spent by service staff on allowable: (1) mental health targeted case management services for children; and (2) mental health targeted case management services for adults and targeted case management services for the group specified in Supplement 1c is applied to the annual costs of providing social services and divided by twelve to arrive at the eligible cost per month. For children, these figures are divided by the average number who received mental health targeted case management services per month. For adults, these figures are divided by the average number received mental health targeted case management services and targeted case management services listed in Supplement 1c to Attachments 3.1-A/B per month.

The result is two separate, monthly payment rates, one for children and one for adults.

19.a. Mental health targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

The two rates represent one month's worth of eligible mental health targeted case management activity. Only one claim per client is allowed per calendar month for mental health targeted case management services provided county ~~and state~~ staff. The rate is the same for medical assistance-eligible and non-medical assistance eligible clients. All of the following conditions must be met in order for a claim to be made:

- the client must be eligible for medical assistance;
- the client received mental health targeted case management services in that month; and
- all documentation requirements are met.

County Rate Formula for Children:

~~The formula described on page 57b.~~

CP = Average monthly social services cost pool for the most recent year for that class of providers

P = Percentage of eligible mental health targeted case management time as identified on the most recent year of the SSTS for that class of providers

N = Monthly average number of clients receiving mental health targeted case management services for that class for providers using the most recent year's worth of data

(CP x P) = Monthly costs of proving mental health targeted case management services for that class of providers

(CP x P)/N = Mental health targeted case management monthly rate for that class of providers

19.a. Mental health targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

County Rate Formula for Adults:

CP = Average Monthly Social Services Cost Pool for the most recent year for that class of providers

P = Percentage of eligible: (1) mental health targeted case management time; and (2) targeted case management (described in Supplement 1c to Attachments 3.1-A/B) time as identified on the most recent year of the SSTS for that class of providers

N = Monthly Average number of clients receiving either mental health targeted case management services or targeted case management services listed in Supplement 1c for that class of providers using the most recent year's worth of data

(CP x P) = Monthly costs of providing targeted case management for that class of providers

(CP x P)/N = Targeted case management monthly rate for that class of providers

19.a. Mental health targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

Rate Methodology for Service Providers under Contract with a County

The monthly rate is determined according to caseload size and includes the following cost and adjustment factors:

i. Wage Factor – Hourly wages for employees providing targeted case management services directly to recipients;

ii. Taxes and Benefits Factor – Employee-related taxes, insurance, and fringe benefits;

iii. Direct Care Hours Factor – The estimated number of direct care hours spent per recipient per month;

iv. Absence Factor – Adjustment for the average amount of billable time that becomes unbillable due to recipient absences;

v. Distribution of Time (Productivity) Factor – Adjustment for time that program staff must spend on non-reimbursable activities;

vi. Training and Paid Time Off Factor – Adjustment for hours that program staff are not available to provide direct services;

vii. Administration Factor – Adjustment for allowable administrative costs associated with service delivery;

viii. Program Support Factor – Adjustment for allowable costs supporting the delivery of services; and

ix. Supervisor Control Factor – Adjustment reflecting the number of direct care workers overseen by one supervisor.

19.a. Mental health targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

Adult mental health rates for providers under county contract

Caseload Size	Payment Rate	Culturally Specific Rate
4-8	$1,781	$1,932
9-13	$971	$1,053
14-18	$668	$724
19-23	$508	$551
Standard	$411	$446
29-33	$344	$373
34-38	$297	$322
39-43	$260	$282
44-48	$232	$252
49-53	$210	$227

Children’s mental health rates for providers under county contract

Caseload Size	Payment Rate	Culturally Specific Rate
3-7	$2,137	$2,318
8-12	$1,068	$1,159
Standard	$712	$772
18-22	$534	$579
23-27	$427	$463
28-32	$356	$386
33-37	$306	$331
38-42	$267	$290
43-47	$237	$257
48-52	$214	$232

The wage and benefit components of the rates are based on the most recent data available from the Bureau of Labor Statistics (BLS). The BLS values are projected to the mid-point of the Medicaid rate year using the Medicare Economic Index. The wage and benefit values will be updated annually, and the rates will be adjusted accordingly. New rates will be effective January 1 of each rate year and published on the Department’s website 180 days prior to the start of the year.

19.a. Mental health targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

Counties may request an adjustment to the standard caseload size. The Direct Care Service Hours Factor used to compute the rate in item (iii) may be adjusted to accommodate variations in caseload size that result when increasing or decreasing the average number of direct care hours provided to recipients. Adjustments to the standard value for caseload size must be preapproved by the Department and must be based on the needs of the specific population of recipients.

Counties may request a rate adjustment for the provision of culturally specific services. The adjustment will provide for an increase to the standard values for the Wage Factor described in item (i) and the Absence Factor in item (iv). Adjustments for culturally specific services must be preapproved by the Department and must be based on the needs of individuals from particular linguistic, racial, ethnic or social backgrounds.

Counties may request adjustments for caseload size and adjustments for the provision of culturally specific services separately or together.

Providers contracting with counties identified below will be paid an adjusted rate for services provided from July 1, 2022 through December 31, 2023. Providers will receive one adjusted rate for the first six month period and a different adjusted rate for the subsequent twelve month period. Effective January 1, 2024, providers contracting with the identified counties will be paid one-hundred percent of the standard rate. At that time, counties may request an adjustment for caseload size and/or the provision of culturally specific services.

County	MH TCM	7/1/22 – 12/31/22	1/1/23 – 12/31/24
Clay	Children	75% of standard rate	88% of standard rate
Itasca	Children	65% of standard rate	80% of standard rate
Itasca	Adults	85% of standard rate	95% of standard rate
Olmsted	Adults	115% of standard rate	105% of standard rate
St. Louis	Adults	115% of standard rate	105% of standard rate

19.a. Child welfare-targeted targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

Eligible contacts for Counties, Tribes and Contracted Service Providers

~~The monthly rate is based on an aggregate of time spent forming all elements of case management services.~~

Payment is based on~~:~~

~~a. A~~a face-to-face contact, either in person or by interactive video, at least once per month between the case manager and the recipient or the recipient's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan in regard to the status of the recipient, the individual service plan, or goals for the recipient.

In-person contact is required for individuals who are placed outside of the home or who are receiving case management service for reasons related to child protection, unless the individual is

~~b. A telephone contact, for Minnesota recipients~~ placed outside the county of financial responsibility in an excluded time facility under Minnesota Statutes, section 260.93, and the placement ~~in either case~~ is more than 60 miles beyond the county or reservation boundaries. ~~The telephone contact must be between the case manager and the recipient or the recipient's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan in regard to the status of the recipient, the individual service plan, or goals for the recipient. There must be at least one contact per month and~~ In that circumstance, service may be delivered via telephone or interactive video, but not for more than two consecutive months without an in-person ~~face-to-face~~ contact ~~as described in item (a) above~~.

Encounter Rate Methodology for IHS or Tribal 638 Providers

The rate is one half of the average monthly child welfare targeted case management rate paid to counties within the tribe's Contract Health Service Delivery Area. The rate is recalculated annually.

19.a. Child welfare-targeted targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

~~An encounter is defined as~~ a ~~face-to-face contact, either in person or by interactive video, or a telephone contact occurring within a 24- hour period ending at midnight, as follows:~~

~~a. A face-to-face contact, either in person or by interactive video, between the case manager and the recipient or the recipient's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan in regard to the status of the recipient, the individual service plan, or goals for the recipient.~~

~~b. A telephone contact between the case manager and the recipient or the recipient's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan in regard to the status of the recipient, the individual service plan, or goals for the recipient.~~

~~This applies to a recipient placed outside the county of financial responsibility or to a recipient served by tribal social services placed outside the reservation, in an excluded time facility under Minnesota Statutes, section 256G.02, subdivision 6, or through the Interstate Compact on the Placement of Children under Minnesota Statutes, section 260.93. The placement must be more than 60 miles beyond the county or reservation boundaries.~~

To be eligible for payment, there must be at least one contact per month. Only one contact within a 24-hour period ending at midnight will be paid, except that eligible contacts ~~encounters~~ with more than one case manager in the same 24-hour period are payable if one case manager from a tribe and one case manager from the county of financial responsibility, or a tribal-contracted or county-contracted vendor, determine that dual case management is medically necessary and documentation of the need and the distinctive services provided by each case manager is maintained in the individual service plan.

19.b. Child welfare-targeted targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

Rate Methodology for Entities Under Contract with Tribal Social Services
The monthly rate for child welfare targeted case management services provided by entities under contract with tribal social services is based on the monthly rate negotiated by tribal social services. The negotiated rate must not exceed the rate charged by the entity for the same service to other payers.

If the service is provided by a team that includes contracted vendors, IHS or 638 facility staff, and state or county staff, the costs for the state or county staff participation in the team must be included in the rate for county-provided services. In this case, the contracted vendor, the IHS or 638 facility 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 client's file, the need for team ~~mental health~~ targeted case management and a description of the roles of team members.

Rate Methodology for Services Provided by County Staff:
A statistically valid random moment time study, Minnesota's Social Services Time Study (SSTS), is used to construct a monthly for child welfare targeted case management services. The SSTS separates time of all direct services staff into a number of categories that constitute allowable ~~mental health~~ targeted case management activities and other unallowable activities. The proportion of allowable to total activities, when multiplied by the overall provider costs establishes the costs of ~~mental health~~ targeted case management activity.

19.b. **Child welfare-targeted case management services** as defined in, and to the group specified in, **Supplement 1a** to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act. (continued)

Rate Methodology for County Staff:

A statistically valid random moment time study, Minnesota's Social Service Time Study (SSTS), is used to construct a monthly rate for child welfare-targeted case management. The SSTS separates a case manager's time into a number of categories which constitute allowable case management activities and other, unallowable activities. The proportion of allowable to total activities, when multiplied by the over-all provider costs establishes the costs of case management activity.

The percentage of time spent by service staff on allowable child welfare-targeted case management services is applied to quarterly costs of providing social services, and divided by three to arrive at the eligible cost per month. This figure is divided by the average number of clients who received case management services per month. The result is the rate used for child welfare-targeted case management. This process is repeated so that valid rates can be established for each class of providers. The SSTS will be valid at each class.

The rate represents one month's worth of eligible child welfare-targeted case management activity and only one claim is allowed per calendar month. The rate is the same for MA-eligible and non-MA-eligible children. In the payment process, *all* of the following conditions must be met in order for a claim to be made:

A. the child is a MA recipient;
B. the child received child welfare-targeted case management services that month; and
C. all documentation requirements are met.

The rate will be reviewed and updated annually, using the most current, available data.

19.b. **Child welfare-targeted case management services** as defined in, and to the group specified in, **Supplement 1a** to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act. (continued)

Rate Formula:

CP = Average Quarterly Social Service Cost Pool for the most recent year for that class of providers

P = Percentage of eligible targeted case management time as identified on the most recent year of the SSTS for that class of providers

N = Monthly Average number of children receiving case management services for that class of providers using the most recent year's worth of data

(CP/3 x P) = Monthly costs of providing child welfare-targeted case management (TCM) for that class of providers

TCM/N = CW-TCM monthly rate for that class of providers

19.b. Child welfare-targeted targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

Rate Methodology for Service Providers under Contract with a County

The monthly rate is determined according to caseload size and includes the following cost and adjustment factors:

i. Wage Factor – Hourly wages for employees providing targeted case management services directly to recipients;

ii. Taxes and Benefits Factor – Employee-related taxes, insurance, and fringe benefits;

iii. Direct Care Hours Factor – The estimated number of direct care hours spent per recipient per month;

iv. Absence Factor – Adjustment for the average amount of billable time that becomes unbillable due to recipient absences;

v. Distribution of Time (Productivity) Factor – Adjustment for time that program staff must spend on non-reimbursable activities;

vi. Training and Paid Time Off Factor – Adjustment for hours that program staff are not available to provide direct services;

vii. Administration Factor – Adjustment for allowable administrative costs associated with service delivery;

viii. Program Support Factor – Adjustment for allowable costs supporting the delivery of services; and

ix. Supervisor Control Factor – Adjustment reflecting the number of direct care workers overseen by one supervisor.

The wage and benefit components of the rates are based on the most recent data available from the Bureau of Labor Statistics (BLS). The BLS values are projected to the mid-point of the Medicaid rate year using the Medicare Economic Index. The wage and benefit values will be updated annually, and the rates will be adjusted accordingly. New rates will be effective January 1 of each rate year and published on the Department’s website 180 days prior to the start of the year.

19.b. Child welfare-targeted targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B, in accordance with 1905(a)(19) or section 1915(g) of the Act.

Caseload Size	Payment Rate	Culturally Specific Rate
3-7	$2,137	$2,318
8-12	$1,068	$1,159
13-17	$712	$772
18-22	$534	$579
Standard	$427	$463
28-32	$356	$386
33-37	$306	$331
38-42	$267	$290
43-47	$237	$257
48-52	$214	$232

Counties may request an adjustment to the standard caseload size. The Direct Care Service Hours Factor used to compute the rate in item (iii) may be adjusted to accommodate variations in caseload size that result when increasing or decreasing the average number of direct care hours provided to recipients. Adjustments to the standard value for caseload size must be preapproved by the Department and must be based on the needs of the specific population of recipients.

Counties may request a rate adjustment for the provision of culturally specific services. The adjustment will provide for an increase to the standard values for the Wage Factor described in item (i) and the Absence Factor in item (iv). Adjustments for culturally specific services must be preapproved by the Department and must be based on the needs of individuals from particular linguistic, racial, ethnic or social backgrounds.

Counties may request adjustments for caseload size and adjustments for the provision of culturally specific services separately or together.

Providers contracting with Itasca County will be paid an adjusted rate for services provided from July 1, 2022 through December 31, 2023. Providers will receive 75% of the standard rate for the first six month period (through December 31, 2022) and 88% of the standard rate for the subsequent twelve month period. Effective January 1, 2024, providers in Itasca County will be paid one-hundred percent of the standard rate. At that time, the county may request an adjustment for caseload size or for the provision of culturally specific services.

19.c. **Re1ocation service coordination services** as defined in, and to the group specified in, Supplement lb to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

Providers bill for relocation service coordination services, including face-to-face, interactive video, and telephone contacts, for the last 180 consecutive days before a recipient's discharge from an institution.

The payment allowed is:

- $15.53/unit when provided by a county, a federally recognized American Indian tribe providing services to recipients through Indian Health service or 638 facilities, or a private vendor.
- A negotiated rate, with a cap of $15.53/unit, for a provider under contract with a county or federally recognized American Indian tribe providing services to recipients through Indian Health Service or 638 facilities.

One unit = 15 minutes.

19.d. Targeted case management services for persons not receiving services pursuant to a §1915(c) waiver who are vulnerable adults or adults with developmental disabilities or related conditions as defined in Supplement lc, to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

~~(1)~~ Payment is made on a monthly basis. Payment is based on at least one contact per month between the case manager and the recipient or the recipient's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan. This contact may occur via telephone, interactive video, or in person.

~~(2) The monthly rate for targeted case management services provided by entities under contract with a county is based on the monthly rate negotiated by the county. The negotiated rate must not exceed the rate charged by the entity for the same service to other payers.~~

~~a) If the service is provided by a team of contracted vendors, the county may negotiate a team rate with the vendor who is a member of the team. The team must determine how to distribute the rate amongst its members. No payment received by contracted vendors will be returned to the county except to pay the county for advance funding provided by the county to the vendor.~~

~~b)~~ If the service is provided by a team that includes contracted vendors and county staff, the costs of county staff participation in the team must be included in the rate for county-provided service. In this case, the contracted vendor 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 client’s file, the need for team case management and a description of the roles of the team members.

19.d. Targeted case management services for persons not receiving services pursuant to a §1915(c) waiver who are vulnerable adults or adults with developmental disabilities or related conditions as defined in Supplement lc, to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

Rate Methodology for services provided by County Staff:

The rate ~~will be~~ is the same as the county rate in effect for mental health targeted case management for adults (item 19.a).

Rate Methodology for Service Providers under Contract with a County

The monthly rate is determined according to caseload size and includes the following cost and adjustment factors:

i. Wage Factor – Hourly wages for employees providing targeted case management services directly to recipients;

ii. Taxes and Benefits Factor – Employee-related taxes, insurance, and fringe benefits;

iii. Direct Care Hours Factor – The estimated number of direct care hours spent per recipient per month;

iv. Absence Factor – Adjustment for the average amount of billable time that becomes unbillable due to recipient absences;

v. Distribution of Time (Productivity) Factor – Adjustment for time that program staff must spend on non-reimbursable activities;

vi. Training and Paid Time Off Factor – Adjustment for hours that program staff are not available to provide direct services;

vii. Administration Factor – Adjustment for allowable administrative costs associated with service delivery;

viii. Program Support Factor – Adjustment for allowable costs supporting the delivery of services; and

ix. Supervisor Control Factor – Adjustment reflecting the number of direct care workers overseen by one supervisor.

19.d. Targeted case management services for persons not receiving services pursuant to a §1915(c) waiver who are vulnerable adults or adults with developmental disabilities or related conditions as defined in Supplement lc, to Attachments 3.1-A/B.

Caseload Size	Payment Rate	Culturally Specific Rate
4-8	$1,781	$1,932
9-13	$971	$1,053
14-18	$668	$724
19-23	$508	$551
24-28	$411	$446
29-33	$344	$373
Standard	$297	$322
39-43	$260	$282
44-48	$232	$252
49-53	$210	$227

The wage and benefit components of the rates are based on the most recent data available from the Bureau of Labor Statistics (BLS). The BLS values are projected to the mid-point of the Medicaid rate year using the Medicare Economic Index. The wage and benefit values will be updated annually, and the rates will be adjusted accordingly. New rates will be effective January 1 of each rate year and published on the Department's website 180 days prior to the start of the year.

Counties may request an adjustment to the standard caseload size. The Direct Care Service Hours Factor used to compute the rate in item (iii) may be adjusted to accommodate variations in caseload size that result when increasing or decreasing the average number of direct care hours provided to recipients. Adjustments to the standard value for caseload size must be preapproved by the Department and must be based on the needs of the specific population of recipients.

Counties may request a rate adjustment for the provision of culturally specific services. The adjustment will provide for an increase to the standard values for the Wage Factor described in item (i) and the Absence Factor in item (iv). Adjustments for culturally specific rates must be preapproved by the Department and must be based on the needs of individuals from particular linguistic, racial, ethnic or social backgrounds.

Counties may request adjustments for caseload size and adjustments for the provision of culturally specific services separately or together.

20. Extended services to pregnant women.

See items 20.a. and 20.b.

20.a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

Payment was derived from the additional costs of delivering these services above and beyond the global prenatal care package.

Procedure Code(s)	Component	Base Rate: 1/1/02
H1001	At Risk Antepartum Management	$64.89
H1002	Care Coordination	$25.95
H1003	Prenatal Education	$38.92
H1004	At Risk Post-Partum Follow-Up Home Visit	$52.79

Effective for services on or after January ~~July~~ 1, ~~2019~~ 2024, antepartum and postpartum doula services are paid at the lower of:

1. The submitted charge, or
2. ~~47.00~~ $100 per session

Effective for services on or after January ~~July~~ 1, ~~2019~~ 2024, doula services provided during labor and delivery are paid at the lower of:

1. The submitted charge, or
2. ~~488.00~~ $1400 per session

The base rates as described in this item are adjusted by the following clauses of Supplement 2 of this Attachment:

A. IHS/638 Facilities
B. Critical Access Hospitals
C. TPL
D. MinnesotaCare Tax Rate Adjustment
E. Modifiers
G. Community and Public Health Clinics increase
I. Exceptions to payment methodology and reconstructing a rate
F. Professional Services Rate Decrease July 2009
G. Professional Services Rate Decrease July 2010

20.b. Services for any other medical conditions that may complicate pregnancy.

Providers are paid in accordance with the specific services methodology set forth elsewhere in this Attachment.

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act).

Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

Not provided.

23. Certified pediatric or family nurse practitioner services.

Certified pediatric or family nurse practitioner services are paid using the same methodology as item 6.d.E., Nurse practitioner services.

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

See items 24.a. through 24.e.

24.a. Transportation.

Effective July 1, 2001, payment for **emergency ambulance transportation** is the greater of:

1) the payment rate in effect on July 1, 2000; or
2) the Medicare unadjusted payment rate; or
3) the established rate for the following codes:
   - ~~A0427 $430.03~~
   - A0429 $430.03

If the provider transports two or more persons simultaneously in one vehicle from the same point of origin, the payment must be prorated according to the following schedule:

NUMBER OF RIDERS	PERCENT OF ALLOWED BASE RATE PER PERSON IN VEHICLE	PERCENT OF ALLOWED MILEAGE RATE
1	100	100
2	80	50
3	70	34
4	60	25
5-9	50	20
10 or more	40	10

Effective for the first day of each calendar quarter in which the price of gasoline as posted publicly by the United States Energy Information Administration exceeds $3.00 per gallon, the commissioner shall adjust the rate paid per mile by one percent up or down for every increase or decrease of ten cents for the price of gasoline. The increase or decrease must be calculated using a base gasoline price of $3.00. The percentage increase or decrease must be calculated using the average of the most recently available price of all grades of gasoline for Minnesota as posted publicly by the United States Energy Information Administration. Rate adjustments described in this paragraph are made once at the beginning of each quarter based on the price published the last week of the previous quarter.

Payment for emergency **air ambulance transportation** is consistent with the level of medically necessary services provided during the recipient's transportation.

Effective January 1, 2001, payment is the lower of:
1) submitted charge; or
2) the Medicare unadjusted base payment rate.

24.a. Transportation.

Additional payment adjustment for emergency transportation providers ~~at Hennepin County Medical Center and the City of St Paul~~. Effective for services delivered on or after July 1, 2013, emergency transportation providers affiliated with Hennepin County Medical Center and the City of St. Paul will receive an additional adjustment for services provided in a calendar year in the ~~first~~ second quarter of each calendar year, within two years following the end of the base year ~~close of the provider's rate year~~. The base year is the calendar year ending two years prior to the year the payment is made. The adjustment equals the difference between average commercial payer rates for the emergency transportation services delivered by providers affiliated with Hennepin County Medical Center and the City of St. Paul and the rates paid to those providers under this section of Attachment 4.19-B during the base year. ~~using rates from the most recently complete calendar year available.~~ Effective for services provided on or after July 1, 2017, the adjustment shall be made for services provided by any non-state, government-owned ambulance provider, not owned by a tribe, who requests the adjustment. Total payments shall be ~~based on the data described below and~~ calculated ~~beginning with payments made in January of each year~~ as follows:

1) For emergency transportation services delivered by eligible providers ~~associated with Hennepin County Medical Center and the City of St. Paul~~, the set of services (by HCPCS code) delivered to Medicaid eligible individuals and billed on a fee-for-service basis shall be determined using MMIS data.

2) ~~Hennepin County Medical Center and the City of St. Paul will supply~~ Eligible providers will supply, from their respective billing systems, the payment rates for their top five commercial payers along with the relative percentage of commercial ambulance charges that each payer represents. Only commercial payers with at least two percent of the provider's total commercial ambulance charges for the relevant HCPCS codes will be included in the calculation of the average commercial rate.

3) The payment rates for each HCPCS code for each of the commercial payers will be averaged to determine the average commercial payer rate for each HCPCS code.

4) For each of the ~~two~~ emergency transportation provider data sets, the average commercial payer rate is multiplied by the Medicaid frequency for the HCPCS codes for that group.

5) For each of the ~~two~~ emergency transportation provider data sets, the Medicaid payment amount is subtracted from the result in paragraph 4 for each HCPCS code.

6) The final payment amount for the ~~two~~ emergency transportation providers is equal to the sum of the amounts in paragraph 5.

24.a. Transportation.(continued)

Payment for station-to-station specialized transportation **for a child receiving EPSDT rehabilitative or personal care services identified on an IFSP or IEP** under the Individuals with Disabilities Education Act (IDEA) and provided by a school district during the day is ~~determined by multiplying the number of miles the child is transported to or from a provider of rehabilitative services by the per mile rate of $2.21~~ pursuant to a cost-based trip rate. The child must receive another covered EPSDT rehabilitative or personal care service identified on an IFSP or IEP on the same day and the need for station-to-station specialized transportation must be identified in an IFSP or IEP.

INTERIM RATE METHODOLOGY

School districts are paid an interim cost-based trip rate using data collected for a prior state fiscal year.

Interim Rate Formula: The interim rate formula is the same as the final rate formula. The rate will be reviewed and updated annually at the start of the state fiscal year on July 1.

FINAL RATE METHODOLOGY

The Department will settle-up with school districts no later than 12 months following the receipt of clean and correct cost data reported by the school districts for the state fiscal year.

24.a. Transportation.(continued)

Final Rate Formula:

1. total district special transportation costs (salaries of drivers only, fringe benefits, gas, oil, insurance, maintenance) divided by the total number of days eligible children are enrolled in the district = per child daily costs
2. per child daily cost divided by 2 = trip cost per child
3. trip cost per child multiplied by the cognizant agency's unrestricted indirect cost percentage for the school district
4. item 2 + item 3 = final rate

The base rates as described in this item are adjusted by the following clauses of Supplement 2 of this Attachment:

D. MinnesotaCare tax rate adjustment
Y. Ambulance services rate decrease 2011
kk. Ambulance services rate increase 2016

24.b. Services of nurses in religious nonmedical health care institutions.

Not provided.

24.c. Care and services provided in religious nonmedical health care institutions.

See Attachment 4.19-D.

24.d. Nursing facility services for patients under 21 years of age.

See Attachment 4.19-D.

24.e. Emergency hospital services.

Emergency hospital services are paid using the same methodology as item 2.a., Outpatient hospital services.

25. Home and community care for functionally disabled elderly individuals.

Not provided.

8. Private duty nursing services.

Payment for private duty nursing services is the lower of the submitted charge or the rate from the chart below.

Service provided on or after	~~7/1/2013~~	4/1/2014	7/1/2014	7/1/2015	1/1/2022	1/1/2023	1/1/2024	1/1/2025
Private Duty Nursing L.P.N. Unit	~~$6.24~~	$6.30	$6.62	$6.69	$7.21	$7.43	$9.57	$9.87
Private Duty R.N. Unit	~~$8.13~~	$8.21	$8.62	$8.71	$9.39	$9.67	$12.46	$12.85
Private Duty L.P.N. (complex)	~~$7.32~~	$7.39	$7.76	$7.84	$8.45	$8.70	$11.21	$11.56
Private Duty R.N. (complex)	~~$9.75~~	$9.85	$10.34	$10.44	$11.25	$11.59	$14.93	$15.40

26. Personal care services.

Payment is the lower of the submitted charge or the rate from the chart below.

Service provided on or after	~~7/1/2014~~	7/1/2015	7/1/2016	8/1/2017	7/1/2019	10/1/2021	1/1/2024	1/1/2025
Personal Care 1:1 unit	~~$4.16~~	$4.27	$4.28	$4.35	$4.45	$4.90	$5.95	$6.21
Personal Care 1:2 unit	~~$3.12~~	$3.20	$3.21	$3.26	$3.34	$3.68	$4.47	$4.67
Personal Care 1:3 unit	~~$2.74~~	$2.81	$2.82	$2.86	$2.93	$3.23	$3.92	$4.09
Supervision of Personal Care unit	~~$7.31~~	$7.50	$7.52	$7.64	$7.82	$11.71	$13.26	$13.84

NOTE: 1 unit = 15 minutes

Shared care: For two recipients sharing services, payment is one and one-half times the payment for serving one recipient. For three recipients sharing services, payment must not exceed two times the payment for serving one recipient. This paragraph applies only to situations in which all recipients were present and received shared services on the date for which the service is billed.

PCA Choice option: Payment is the same as that paid for personal care assistant services.

Enhanced payment for services provided to persons with complex needs: Effective for services provided on or after July 1, 2019, the Department will increase the payment rates above by 7.5 percent for personal care assistant services provided to a recipient whose assessment indicates the need for at least 12 hours of personal care services per day. Effective for services provided on or after January 1, 2022, this enhanced payment applies to rates for personal care assistant services provided to a recipient whose assessment indicates the need for at least 10 hours of personal care services per day.

~~In order for providers to receive the increased payment rate, the personal care assistant providing services must have completed training approved by the Commissioner. This increase does not apply to supervision of a personal care assistant.~~

26. Personal Care Services (continued)

Rate Enhancements:

Payment for personal care assistant services is 107.5 percent of the base rate for services provided to a recipient whose assessment identifies at least 10 hours of personal care services per day.

In order for providers to receive the increased payment rate, the personal care assistant providing services must have completed training approved by the Commissioner. This increase does not apply to supervision of a personal care assistant.

A rate enhancement is also paid based on the experience of support workers according to the following formula (and applies to the 1:1, 1:2, and 1:3 shared care rates). Workers must provide more than 1000 cumulative hours of PCA or CFSS services under sections 1905(a) for PCA, 1915(c) for extended PCA and extended CFSS, and under sections 1915(i) and 1915(k) for CFSS. The calculation is based on the cumulative hours worked beginning on July 1, 2017. Where the 107.5 percent rate enhancement and the enhancement for worker experience applies, the 107.5 percent amount is the base for calculating this additional enhancement.

The enhancement is as follows:
(1) for workers who have provided between 1,001 and 2,000 cumulative hours, the amount is 2.17 percent;

(2) for workers who have provided between 2,001 and 6,000 cumulative hours, the amount is 4.36 percent;

(3) for workers who have provided between 6,001 and 10,000 cumulative hours, the amount is 7.35 percent; and

(4) for workers who have provided more than 10,000 cumulative hours, the amount is 10.81 percent.

28. Freestanding birth center services.

Traditional midwives are paid the lower of the:

1) submitted charge; or

2) 100% of the rate paid to a physician performing the same services, using the same methodology as item 5.a., Physician services.

Effective for services provided on or after January 1, 2011, payment for birth center facility services is the lower of:

(1) the submitted charge;

(2) 70 percent of the statewide average for a facility payment rate made to a hospital for an uncomplicated vaginal birth as determined using the most recent calendar year for which complete claims data is available; or

(3) 15 percent of the average facility payment made to a hospital for the services provided for an uncomplicated vaginal delivery as determined using the most recent calendar year for which complete claims data is available, when a recipient is transferred to a hospital prior to the delivery.

Effective for services provided on or after January 1, 2011, payment for nursery care facility services provided by a birth center is the lower of:

(1) the submitted charge; or

(2) 70 percent of the statewide average for a payment rate paid to a hospital for nursery care as determined using the most recent calendar year for which complete claims data is available.

The base rates as described in this item are adjusted by the following clauses of Supplement 2 of this Attachment:

W. Professional services rate decrease 2011

29. **Integrated Care Models (FFS Primary Care Case Management)**

Integrated Health Partnership (IHP) ~~Demonstration~~Program, Payment Adjustment.

Payment for~~ legacy and~~ track 2 IHP services includes a payment, made at the end of each participation year, for qualified IHP ~~demonstration~~ provider~~s~~ organizations that have agreed to participate for the purpose of improving quality and achieving efficiencies across the total cost of care for a broad spectrum of outpatient and inpatient care as a common financial and organization entity. Payment is distributed to participating providers through the ~~demonstration~~ IHP ~~provider~~ entity.

"Participation year" is the first twelve-month period of participation in the IHP program by an IHP entity, and each twelve-month period thereafter. "Base year" is the twelve-month period immediately preceding the first participation year of each ~~three-year~~ contract period.

~~Legacy IHP Entities~~
~~Payment is limited by the IHP's performance for the participation year against identified quality measures., and tThese quality measures are reflective of the populations, capabilities and services provided by the IHP providers, for Medical Assistance enrolled patients attributed to the delivery system for the participation year. The payment for the year is based on the difference between the annual expected, or target, total cost of care (TCOC) and the actual, realized TCOC for the core services, plus the TCOC for additional services agreed upon by the Department and the IHP demonstration provider, for the population attributed to the demonstration provider.~~

~~Gain-sharing and loss-sharing will occur only if the IHP provider achieves a 2% or greater savings or loss between the target total cost of care and the actual, realized total cost of care. Payment will be different between virtual and integrated delivery models. Payment for virtual delivery models includes gain-sharing, with the option to include loss-sharing; payment for integrated models includes both gain-sharing and loss-sharing. For integrated models, and for virtual models in which the IHP entity elects to accept loss-sharing, payment can be positive or negative. The determination of both the base and the target TCOC includes both fee-for-service and managed care enrollees, but the~~

29. **Integrated Care Models (FFS Primary Care Case Management)** Integrated Health Partnership (IHP) ~~Demonstration~~Program, Payment Adjustment (continued).

Payment for IHP services will also include quarterly, retrospective, population-based payments for qualified IHP entities that have agreed to participate in either track 1 or track 2 of the ~~demonstration~~IHP program. The population-based payments are based on the characteristic of being an IHP entity, which includes the ability to evaluate, intervene, and improve the health of attributed patients. Payments reflect the relative risk and complexity of an IHP's attributed population. For each IHP, the Department calculates the population-based payment as follows:

1. For each attributed member in the previous quarter, the Department calculates a risk score using the Johns Hopkins ACG or other risk grouper.
2. Each attributed member is then assigned an individual per member per month payment (PMPM) based on their risk score.
3. Each attributed member's PMPM is adjusted using a social risk weight.
4. The Department then aggregates the PMPM calculated in step 3 for each attributed member, and divides the total by the number of attributed members.

This creates an average population-based payment that is paid quarterly to the IHP for each attributed member in the previous quarter.

Track 1 and track 2 IHP entities may not receive health care home payments or payments for in-reach care coordination services.

Attribution, covered population, exclusions, population limits. For both the base year and for the participation year, the Department will attribute fee-for-service patients to the IHP provider retrospectively, using fee-for-service paid claims data.

29. **Integrated Care Models (FFS Primary Care Case Management)**
Integrated Health Partnership (IHP) ~~Demonstration~~Program, Payment Adjustment (continued).

Risk score. For both the base year and the participation year, the Department will calculate a risk score based on diagnoses for the population attributed to the IHP ~~demonstration~~ provider. The target TCOC will be adjusted based on the increase or decrease in the risk of the attributed populations between the base year and the participation year.

Total cost of care. The TCOC for the base period and the measurement period will be calculated by the Department retrospectively, using fee-for-service claims data and encounter data from the managed care organizations. The cost in the base and participation years will include the cost of the core services and any other additional services jointly agreed upon between the Department and the ~~demonstration~~ IHP~~provider~~, for the population attributed to the ~~demonstration~~ IHP~~provider~~. The services included in the TCOC measurement for the base year and measurement year will be identical. The total cost of care will not include individual annual claims costs in excess of a catastrophic threshold of at least $50,000.

The target TCOC will be developed using the prior years' TCOC for the IHP, plus expected trend, which will be the expected trend for the aggregate Minnesota Health Care Programs with appropriate adjustments for services not included in the base TCOC and incorporating actual IHP program trend as appropriate and methodologically sound.

Beginning January 1, 2018, population-based payments will be included in the TCOC calculation for track 2 entities.

~~**Gain and Loss-Sharing for Legacy IHP Providers.** For the virtual model, loss-sharing is not required. For all participation years, the IHP provider shares equally with the state any gains between the target total cost of care and the realized total cost of care, reduced by the results from the quality measures. A virtual IHP may accept loss-sharing within terms agreed upon between the IHP and the state.~~

29. **Integrated Care Models (FFS Primary Care Case Management)**
Integrated Health Partnership (IHP) ~~Demonstration~~Program, Payment Adjustment (continued).

~~For the integrated model, the effect of the performance measures on the gain-sharing payment is the same as for the virtual model. Loss-sharing and gain-sharing between the state and the demonstration providers are as follows:~~

~~Year 1: gain-sharing only, when the performance threshold is met (2% savings), shared equally between the state and the demonstration provider.~~

~~Year 2: the provider must accept some risk for losses (actual cost above target TCOC), in addition to the potential for shared gains. There is no minimum amount loss-sharing threshold that the provider must accept, but the ratio of gain-sharing to loss-sharing thresholds must be must be two to one. All gains and losses are shared evenly with the state.~~

~~Year 3: the provider must accept some risk for losses in addition to the potential for shared gains. There is no minimum loss-sharing threshold that the provider must accept, but the ratio of gain-sharing to loss-sharing thresholds must be symmetrical. Gains and losses are shared between the demonstration provider and the state at negotiated proportions and may not be shared evenly.~~

~~Year 4 and thereafter: the provider must accept some risk for losses, in addition to the potential for shared gains. There is no minimum loss-sharing threshold that the provider must accept, but the ratio of gain-sharing to loss-sharing thresholds must be symmetrical. Gains and losses are shared between the demonstration provider and the state at negotiated proportions. If the IHP agrees to expand the type of services included in the base year, participation year and target TCOC beyond those listed under core services below, or agrees to expand the number of participants in the IHP, then the IHP's ratio of gain-sharing to loss-sharing thresholds may be asymmetrical, with all gains and losses shared evenly with the state. An asymmetrical ratio of gain-sharing to loss-sharing is a risk corridor with a larger threshold for gain than loss. The IHP's risk arrangement for new, expanded services may differ from the IHP's risk for the core services.~~

25b.~~29.~~ **Integrated Care Models (FFS Primary Care Case Management)**
Integrated Health Partnership (IHP) ~~Demonstration~~Program, Payment Adjustment (continued).

Gain- and Loss-Sharing for Track 2 IHP Providers. Track 2 IHP entities must accept some risk for losses, in addition to the potential for shared gains. There is no minimum loss-sharing threshold that the provider must accept. Gains and losses are shared between the ~~demonstration~~ IHP~~provider~~ and the state at negotiated proportions. The state will eliminate shared losses for any month(s) where at least 20% of an IHP's attributed population resides in a county or counties that are impacted by an extreme and uncontrollable circumstance. The state will use the determination of an extreme and uncontrollable circumstance by the HHS Secretary for the Center for Medicare and Medicaid's (CMS) Quality Payment Program, including the identification of affected geographic areas and applicable time periods, for purposes of determining the applicability of the extreme and uncontrollable circumstances policies with respect to the IHP program. When at least 20% of an IHP's attributed population resides in a region that is impacted by a declared extreme and uncontrollable circumstance, then the state would reduce shared losses by an amount determined by multiplying the shared losses by the percentage of the total months in the performance year affected by the extreme and uncontrollable circumstance, and the percentage of the Integrated Health Partnership's (IHP) assigned beneficiaries who reside in an area affected by the extreme and uncontrollable circumstance.

Quality Measures. Gain-sharing and loss-sharing payments will be affected by quality measures. ~~For legacy IHP providers, the measure for reporting data in accordance with requirements will have a 25% effect on the shared savings payments in year 1; meaning that 25% of the dollar amount saved shall be reducible by the percentile score calculated for this measure. For year 2, the quality measures will have a 25% effect on the shared savings payments. For year 3, the quality measures will have a 50% effect. For all subsequent years, the effect of the quality measures will be negotiated between the Department and the demonstration provider.~~

For track 2 IHP providers, the effect of the quality measures will be negotiated between the Department and the ~~demonstration~~ IHP. The effect of the quality measures shall be no more than ~~50%~~100%, and no less than 25%.

For track 1 and track 2 providers, the Department shall determine each entity's ability to continue receiving population-based payments ~~in year 4 and thereafter~~ after year 3 and before entering into a future contract, based on the entity's performance on select quality measures.

29. **Integrated Care Models (FFS Primary Care Case Management)**
Integrated Health Partnership (IHP) ~~Demonstration~~Program, Payment Adjustment (continued).

~~The state will notify IHP entities, prior to the participation year, of the minimum attainment threshold and upper threshold scores that will result in the maximum reduction or zero reduction in the shared savings payment, by publishing the methodology on the DHS website prior to January 1 of each participation year.~~

The measures used in the calculation are consistent with the Minnesota Statewide Quality Reporting and Measurement System, which includes measures from state- and nationally-recognized sources, such as Minnesota Community Measurement, HEDIS, and other NQF-endorsed measures. The measures are posted on the Department's webpage describing Integrated Health Partnerships, and are updated once per year. The updates will be incorporated into ~~this~~ the ~~demonstration~~ IHP program each participation year and will be the measures used for that participation year. The IHP ~~demonstration~~ program allows for some substitution of measures as appropriate for the population and upon Department approval.

The state will calculate an overall quality score for each IHP by assigning points to each measure, calculating a composite quality score for each measure category ~~(e.g. clinical, patient experience)~~ and assigning a weight to each measure category. The percentage of total points earned is multiplied by the shared savings or losses amount subject to quality in the applicable participation year. The thresholds for each measure will be applied consistently amongst participating IHP entities.

Attribution methodology: populations excluded. For purposes of both the base year and the participation year TCOC and other performance measures, attribution of patients occurs at the beginning and the end of the year using retrospective claims data. Participants will be attributed to one IHP provider at a time. Attribution will be done using a hierarchical process as follows:

29. **Integrated Care Models (FFS Primary Care Case Management)**
Integrated Health Partnership (IHP) ~~Demonstration~~Program, Payment Adjustment (continued).

1. Participants actively receiving care coordination through a certified health care home (see item 5a of Attachments 3.1-A and 3.1-B), a behavioral health home as described in Attachment 3.1-H, or other mechanism that provides a comprehensive system of care coordination for Medicaid beneficiaries, as determined by the state.

2. Participants for whom a plurality of their evaluation and management visits/encounters are with a primary care physician participating in the IHP ~~demonstration~~program;

3. Participants for whom a plurality of their evaluation and management visits/encounters are with a ~~demonstration~~IHP-participating, non-primary care physician;

The state may modify the process identified above to ensure that participants are appropriately attributed to the IHP where most of the participant's care and/or care coordination occurs.

Participants will be attributed to the IHP ~~demonstration~~ provider whether enrolled in managed care or fee-for-service. Attributed participants will be treated as a common risk pool for purpose of the total cost of care calculation and the payment model, except persons with private health coverage will not be included in the payment model, as described below. The amount of payment made to the ~~demonstration~~ IHP~~provider~~ for its fee-for-service patients will be the pro-rated share of the risk/gain payment described above.

The following populations are excluded from participation in the IHP ~~demonstration~~ program and therefore are not included in the attribution process:

29. **Integrated Care Models (FFS Primary Care Case Management)**
Integrated Health Partnership (IHP) ~~Demonstration~~Program, Payment Adjustment (continued).

1. People dually eligible for Medicare and Medical Assistance;

2. Qualified Medicare beneficiaries who are not otherwise receiving Medical Assistance services;

3. Non-citizens receiving only emergency Medical Assistance;

4. Persons eligible for Medical Assistance on a spend-down basis;

5. Persons enrolled in the specialty Medical Assistance managed care product entitled the Minnesota Senior Care Plus program.

6. Participants for whom payment data is incomplete due to third party liability, including those with cost-effective, employer-sponsored health coverage and those with private HMO coverage.

29. **Integrated Care Models (FFS Primary Care Case Management)**
Integrated Health Partnership (IHP) ~~Demonstration~~Program, Payment Adjustment (continued).

Core Services. Services included in the base year, participation year and target TCOC are:

> Physician services; nurse midwife; nurse practitioner; Child & Teen Check-up (EPSDT); public health nurse; rural health clinic; federally qualified health center; laboratory; radiology; chiropractic; pharmacy; vision; podiatry; physical therapy; speech therapy; occupational therapy; audiology; mental health; chemical dependency; outpatient hospital; ambulatory surgical center; inpatient hospital; anesthesia; hospice; home health (excluding personal care assistant services); and private duty nursing.

IHP entities may negotiate with the Department to include additional services in the TCOC calculation.

30. Routine patient costs for items and services furnished in connection with participation in a qualifying clinical trial

Routine Patient Costs Furnished in Connection with Participation in Qualifying Clinical Trials Reimbursement for services is the lesser of charges or the Medicaid fee schedule amount. A maximum allowable fee is established by procedure code regardless of provider location. All public and private providers are reimbursed according to the same fee schedule. Providers may access the fee schedule at https://mn.gov/dhs/assets/mhcp-fee-schedule_tcm1053-294225.pdf.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: MINNESOTA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to the State plan fee-for-service fee schedule rates and payment methodologies, regardless of whether the provider would otherwise receive payment under a different methodology described in the State Plan, for the groups and payments listed below and designated with the letters "SP."

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item _ of this Attachment (see 3, below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."

3. Payments are up to the amount of a special rate or according to a special method, described on Page 3 in item A of this Attachment, for those groups and payments listed below and designated with the letters "NR."

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in items A and B of this Attachment (see 3, above).

NR - Nursing Facility Payment, Part A Coinsurance

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: MINNESOTA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs: Part A MR Deductibles MR Coinsurance
Part B SP Deductibles SP Coinsurance

Other Medicaid Recipients:

Part A MR Deductibles MR Coinsurance
Part B SP Deductibles SP Coinsurance

Dual Eligible (QMB Plus):

Part A MR Deductibles MR Coinsurance
Part B SP Deductibles SP Coinsurance

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: MINNESOTA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Item A. **Nursing Facility Payment, Part A Coinsurance**

Medicaid payment is the lesser of the actual coinsurance amount or the amount by which the Medicaid State plan case mix payment rate exceeds the Medicare rate less the coinsurance amount.

Item B. **Part B Coinsurance and Deductibles**

Medicaid Payment is the Medicare allowed amount for the following services:

- Mental health services, except for psychiatrist services and advanced practice nurse services.
- Dialysis for end stage renal disease.
- Durable medical equipment subject to the Medicare Durable Medical Equipment Prosthetics/Orthotics and Supplies (DMEPOS) competitive bidding program.
- Services provided by a federally qualified health center, Indian Health Service (IHS) facilities and tribal providers operating under 638 agreements, or a rural health clinic.
- Services provided by Certified Community Behavioral Health Centers (CCBHCs). CCBHC services are offered under the Rehabilitative Services benefit.

A. IHS/638 and Tribal FQHC Facilities

Tribal facilities are clinic service providers. Except for child welfare-targeted case management services and relocation service coordination services, services provided by facilities of the Indian Health Service (which include, at the option of a tribe, facilities owned or operated by a tribe or tribal organization, and funded by Title I of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act., P.L. 106-260, operating as 638 facilities) are paid at the outpatient all-inclusive rates (AIR) negotiated between the Indian Health Service and the Centers for Medicare & Medicaid Services (CMS) and published ~~by the Indian Health Service~~ in the Federal Register. Child-welfare targeted case management services are paid in accordance with the methodology in item 19.b., child welfare-targeted case management services. Relocation service coordination services are paid in accordance with the methodology in item 19.c, relocation service coordination services.

An encounter for a 638 or IHS facility means a face-to-face encounter/visit between a recipient eligible for Medical Assistance and any health professional at or through a IHS, or 638 service location for the provision of Title XIX covered services in or through an IHS or 638 facility within a 24-hour period ending at midnight. Encounters/visits with more than one health professional and multiple encounters/visits with the same professional, within the same service category, that take place in the same 24-hour period, constitute a single encounter/visit, except when the recipient after the first encounter/visit suffers an illness or injury requiring additional diagnosis or treatment. Service categories for IHS/638 facilities are: ambulance, chemical dependency, dental, home health, medical, mental health, and pharmacy.

Telehealth visits provided through real-time interactive audio and video communication may be used to satisfy the face-to-face requirement.

Tribes may elect to be designated as tribal Federally Qualified Health Centers (FQHCs). Enrolled Tribal FQHCs are reimbursed an alternate payment methodology (APM)that is equal to the outpatient all- inclusive rate (AIR) rate negotiated between the Indian Health Service and CMS for tribal facilities. The APM is at least equal to the tribal Prospective Payment System(PPS). Participating tribal FQHCs receive the APM for the same categories of FQHC service that they receive the AIR. Payment shall be made in accordance with the AIR rate methodology detailed in this supplement.

B. Critical Access Hospitals

Outpatient services provided by facilities defined in state law as critical access hospitals (and certified as such by the Centers for Medicare & Medicaid Services) are paid on a cost-based payment system based on the cost-finding methods and allowable costs of Medicare.

C. Third Party Liability

In accordance with Minnesota Statutes, §2568.37, subdivision 5a: No Medical Assistance payment will be made when covered charges are paid in full by a third party payer or the provider has an agreement with a third party payer to accept payment for less than charges as payment in full.

Payment for services for patients that are simultaneously covered by Medical Assistance and a liable third party other than Medicare will be made as the lesser of the following:

a. the patient liability according to the provider/third party payer (insurer) agreement;
b. covered charges minus the third party payment amount; or
c. the Medical Assistance rate minus the third party payment amount.

D. MinnesotaCare Tax Rate Adjustment

The total payment for services provided ~~on or after January 1, 2020~~, is increased by an amount equal to the MinnesotaCare tax rate on gross Medicaid fee-for-service revenue for the respective fiscal year~~.8 percent for the following Minnesota providers and services~~. The rate adjustment is the same for government and non-governmental providers. This is an increase to the rate methodology described elsewhere in this Attachment for the following Minnesota providers and services. This rate increase is applied after all other payment rate increases or decreases described below.

- outpatient hospital services (Item 2.a)
- x-ray services (Item 3)
- EPSDT services, excluding rehabilitative services and services provided to a recipient with severe emotional disturbance residing in a children's residential treatment facility (Item 4.b)
- physicians' services (Item 5.a)
- medical and surgical services furnished by a dentist (Item 5.b)
- podiatrists' services (Item 6.a)
- optometrists' services (Item 6.b)
- chiropractors' services (Item 6.c)
- other practitioners' services: mental health, public health nursing, ambulatory surgical center, certified registered nurse anesthetist, nurse practitioner, case management services provided as a component of receiving clozapine, and clinical nurse specialist services (Item 6.d)
- clinic services (Item 9)
- dental services (Item 10)
- physical therapy services (Item 11.a)
- occupational therapy services (item 11.b)
- speech, language, and hearing therapy services (Item 11.c)
- dentures (Item 12.b)
- eyeglasses (Item 12.d)
- diagnostic, screening, and preventive services (Items 13.a, 13.b, and 13.c)
- rehabilitative services: day treatment for mental illness, rehabilitative restorative

and specialized maintenance physical therapy, occupational therapy, and speech, language and hearing therapy services, and respiratory therapy services (Item 13.d)

- services for individuals age 65 or older in institutions for mental diseases (Item 14)
- inpatient psychiatric facility services for individuals under 22 years of age (Item 16)
- nurse midwife services (Item 17)
- pregnancy-related and postpartum services for 60 days after the pregnancy ends (Item 20.a)
- services for any other medical condition that may complicate pregnancy (Item 20.b)
- certified pediatric or family nurse practitioner services (Item 23)
- licensed ambulance services, excluding volunteer ambulance services (Item 24.a)
- emergency hospital services (Item 24.e)
- the drug ingredient component of pharmacy services (item 12.a, effective July 1, 2019, at 1.8 percent.
- Services of rural health clinics (item 2.b.), for health care home services, behavioral health home services, and alternative payment methodologies II and III.
- Services of federally qualified health centers (FQHCs)(item 2.c), for health care home services, behavioral health home services, and alternative payment methodologies II and III.

D. Modifiers

22 modifier: unusual procedural services = additional reimbursement based on line description or claim attachment. This modifier specifies a ratio for twin delivery and VBAC delivery. All other services are priced according to the service rendered.(Item 5.a)

99 modifier: multiple modifier = may be an increase or a decrease to the reference file allowable depending on the modifiers represented within the 99. (Item 5.a)

E. Family Planning

Effective for services provided on or after July 1, 2007, **family planning services** provided by family planning clinics, public health clinics and community health clinics are paid 25% over the rate in effect on June 30, 2007. (Item 5.a.)

Effective for services provided on or after July 1, 2013, **family planning services** provided by family planning clinics, public health clinics and community health clinics are paid 20% over the rate in effect on June 30, 2013. (Item 5.a.)

Effective for services provided on or after January 1, 2024, **family planning services** provided by family planning clinics, public health clinics and community health clinics are paid 20% over the rate in effect on December 31, 2023. The increase does not apply to Federally Qualified Health Centers, Rural Health Centers, or Indian Health Services.(Item 5.a.)

F. Community and Public Health Clinic

Effective July 1, 1989, rates for services provided by **community and public health** clinics are increased by 20%, except for laboratory services. Effective January 1, 2022, dental services are excluded from this increase.

G. Abortion

Effective for services provided on or after January 1, 2024, **abortion services** are paid 20% over the rate in effect on December 31, 2023. The increase does not apply to Federally Qualified Health Centers, Rural Health Centers, or Indian Health Services. (Item 5.a.)

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic.

A clinic receives payment based on payment methodology in effect on December 31, 2000 until its prospective payment system (PPS) rate(s) is/are determined in accordance with §1902(bb) of the Social Security Act. The Department will reconcile a clinic's payments back to January 1, 2001 when the clinic's PPS rate(s) is/are determined. The PPS and alternative payment methodology (APM I, APM II, and APM III) rates for clinics will include a rate for dental services, if provided, and a rate for all other rural health clinic services of the provider or provider group. Hereinafter, "all other rural health clinic services of the provider or provider group" will be referred to as "medical services."

Prospective Payment System (PPS) Methodology

Rates are computed using a clinic's fiscal year trended forward to December 31, 2000. For the purposes of compliance with §1902(bb)(6) of the Act, the inflation of the rate will occur each year on January 1. January 1 through December 31 will be the "fiscal year." If applicable, the clinic must provide information regarding changes in the scope of services, including the budgeted cost of providing new services and any projected increase or decrease in the number of encounters due to the change. Any adjustment to the clinic's rate for changes in the scope of services will be effective on the first day of the month following the scope of services change. When determination of the revised PPS rate occurs after the revised rate's effective date, retroactive claims adjustments to the revised rate will be made back to the effective date.

In order to comply with §1902(bb) of the Act, the Department utilizes a formula using a clinic's fiscal year 1999 and fiscal year 2000 cost report information trended forward to December 31, 2000. The trended costs for the two fiscal years are combined and divided by the combined encounter information for the two years, resulting in the average cost rate. Encounters include all face-to-face encounters provided by clinic professionals, including all encounters provided by clinic staff outside of the clinic to clinic patients. Telehealth visits provided through real-time interactive audio and video communication may be used to satisfy the face-to-face requirement.

In order to comply with §1902(bb)(4) of the Act, for a clinic that first qualifies as a clinic provider beginning on or after fiscal year 2000, the Department will compare the new clinic to other clinics in the same or adjacent areas with similar caseloads. If no comparable provider exists, the Department will compute a clinic-specific rate based upon the clinic's budget or historical costs adjusted for changes in the scope of services.

J. **Copay converted to $3.00 provider rate reduction**
A $3.00 rate reduction is applicable to the following services provided to recipients for whom **copays** had been required prior to January 1, 2009:

Eyeglass services; (Item 12.d)
Non-preventive services within the following categories;
Physicians (Item 5.a)
Public health nursing (Item 6.d.B)
Optometry (Item 6.b)
Podiatry (Item 6.a)
Chiropractic (Item 6.c)
Audiology (Item 11.c)
Opticians (Item 12.d)
Nurse practitioners (Item 6.d.E)
Nurse midwives (Item 17)
Traditional midwives (Item 28)
Clinical nurse specialists (Item 6.d.H)
Physician assistants (Item 5.a)

K. **Copay converted to $2.50 provider rate reduction**
A $2.50 rate reduction is applicable to outpatient hospital facility services provided to recipients for whom **copays** for non-emergency visits to hospital-based emergency rooms had been required prior to January 1, 2011. (Item 2.a.)

L. **Rehabilitation Agency Rate Increase Effective July 1, 1993**
Physical therapy, occupational therapy or speech pathology and audiology services provided by a home health or medical rehabilitation agency are paid using the same methodology as item 5.a, Physicians' services. Effective July 1, 1993, payments are increased by 38% for physical therapy, occupational therapy, and speech pathology and mental health services provided by an entity that:

(1) is licensed under Minnesota Rules, parts 9570.2000 to 9570.3400 that operate residential programs and services for the physically handicapped;

(2) is Medicare certified as a comprehensive outpatient rehabilitation facility as of January 1, 1993; and

(3) for which at least 33% of the patients receiving rehabilitation services in the most recent calendar year are recipients of medical assistance, general assistance medical care, and MinnesotaCare. (Item 7.d)

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (continued)

For FQHC payments, "visit" means a face-to-face encounter between a FQHC patient and any health professional whose services are paid under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Telehealth visits provided through real-time interactive audio and video communication may be used to satisfy the face-to-face requirement.

The State uses the FQHC's audited Independent Rural Health Clinic/Freestanding Federally Qualified Health Center worksheet, Statistical Data, and Certification Statement to establish payment rates. The State makes adjustments for:

A. Medicaid coverage of services that differs from Medicare coverage;

B. the applicable visits; and

C. the establishment of a separate dental payment rate, if dental services are provided.

The State limits like services for Medicare and Medicaid to the respective Medicare limit for the year. Time periods that span more than one calendar year are limited to the respective Medicare limit for each time period.

Ratable Increases and Decreases

The following rate increases or decreases are cumulative. They do not apply to cost based Federally Qualified Health Centers, Rural Health Centers, 638 facilities, Indian Health Services, or Medicare crossover claims.

M. **Rate Decrease Effective July 1, 2002:** Total payment paid to hospitals for outpatient hospital facility services provided on or after July 1, 2002, is decreased by .5 percent from current rates. (Item 2.a)

~~N. **Rate Decrease Effective March 1, 2003:** Total payment paid to hospitals for outpatient hospital facility services provided on or after March 1, 2003 and through June 30, 2003, is decreased by 5 percent from current rates. (Item 2.a).~~

~~O. **Rate Increase Effective October** 1 **2007 and July 1, 2008:** Payment rates for the psychotherapy components of children's therapeutic services and supports are increased by 2% effective with service date October 1, 2007, and an additional 2% effective with service date July 1, 2008. (item 4.b)~~

~~P. **Rate Increase Effective July** 1**, 2007:** Effective July 1, 2007, rates for the services below are increased 23.7% when provided by:~~
~~1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;~~
~~2) community mental health centers described in Attachment 3.1-A and 3.1-B at item 6.d.A; or~~
~~3) essential community providers as designated under Minnesota Statutes §62Q.19,in mental health clinics and centers certified under Minnesota Rules, parts 9520.0750 to 9520.0870, or hospital outpatient psychiatric departments and other providers of children's therapeutic services and supports.~~
~~The rate increases for providers identified in clauses 1-3 above, are applied to the following procedure codes:~~

~~90785~~
~~90791 - 90792~~
~~90801 - 90829~~
~~90832 - 90840~~
~~90846 - 90847~~
~~**90849**~~
~~**90853**~~
~~90857~~
~~**90862**~~
~~90875 - 90876~~
~~90887~~
~~96101 - 96103~~
~~96116~~

P. Rate Increase Effective July 1, 2007: Effective July 1, 2007-December 31, 2024, rates for the services below are increased 23.7%. Effective January 1, 2025-December 31, 2025 rates for the services below are increased by 11.85%. Effective January 1, 2026-December 31, 2026 rates for the services below are increased by 5.92% when provided by:

1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;
2) community mental health centers described in Attachment 3.1-A and 3.1-B at item 6.d.A; or
3) essential community providers in mental health clinics and centers or hospital outpatient psychiatric departments and other providers of children's therapeutic services and supports.

The rate increases for providers identified in clauses 1-3 above, are applied to the following procedure codes:

90785
90791-90792
90832 - 90840
90846 - 90847
90849
90853
90875
90887
96116
96121
96130-96133
96136-96139
96146
99202-99205
99211-99215
99221-99223
99231-99236
99238-99239
99242-99245
99252-99255
9281-99285
99304-99310
99315-99316
99341-99345
99347-99350
99360
99381-99387
99391-99397
99401-99404
99406-99409
99411-99412

(See items 4.b, 5.a, 6.d, 13.d)

Effective January 1, 2027 rates for the services above will not receive an increase.

~~99201 - 99285~~
~~99304 - 99364~~
~~99381 - 99412~~
~~H2012 HK H2014 UA HQ H2019 UA HE M0064~~

~~(See items 4.b, 5.a, 6.d, 13.d)~~

4) **Rate Decrease Effective July 1, 2008:** Total payment paid to hospitals for outpatient hospital facility services provided on or after July 1, 2008, before third party liability and spenddown, is decreased by 3 percent. This decrease does not include psychiatric diagnostic categories. (item 2.a)

5) **Professional Services Rate Decrease 2009**

Effective for services, except as noted in **R.l,** provided on or after July 1, 2009, the following services payment rates are reduced by 5 percent. Effective for services provided on or after July 1, 2009 and before July 1, 2010, the following services payment rates are reduced an additional one and one half percent:

Radiology (Item 3) Physician
(Item 5.a)
Physician assistant (Item 5.a)
Podiatry (Item 6.a)
Vision (Item 6.b)
Chiropractic (Item 6.c)
Nurse practitioner (Item 6.d.E.)
Clinical nurse specialist (6.d.H)
Medication therapy management (Item 6.d.I)
Physical therapy (Item 11.a.)
Speech therapy (Item 11.c)
Occupational therapy (Item 11.b)
Audiology (Item 11.c.)
Nurse midwife (Item 17) Traditional
midwife (Item 28)

R.l. Noted exceptions to clause R:

1. Procedure code 99000-99999 when performed by treating providers physician, nurse practitioner, nurse midwife, clinical nurse specialist, physician assistant and the pay-to-provider is a family planning agency.
2. Procedure code 99201-99215, 99381-99412 when performed by treating provider specialties general practitioner, geriatric nurse practitioner, family nurse practitioner, geriatrician, family practitioner, or primary care.
3. 90281-90399, 90476-90749, G9142 (vaccines), 90465-90474 when provided with MN Vaccines for Children, 96372-96379 when provided with MN vaccines for Children, G9141 (administration), A4641-A4642,

A9500-A9700, C9113-C9253, J0120-J9999, Q0144-Q0181, Q2004, Q2009, Q2017, Q3025-Q3026, Q4080-Q4099, Q9951-Q9967, S0012-S0197, S8085 (injections), S4989, S4993
4. G9002 (coordinated care fee)
5. S0280-S0281 (health care home)
6. Teaching sites
7. Performance based payments
8. Vaccine administration
9. Mental health services provided through physicians
10. Anesthesia services

S. Professional Services rate decrease 2010

Effective for services, except as noted in **S.1**, provided on or after July 1, 2010, the following services payment rates are reduced an additional 7 percent (cumulative 12 percent (5 percent from 07/01/09 and 7 percent from 07/01/10)):

Radiology (Item 3.),
Physician (Item 5.a.),
Physician assistant (Item 5a),
Podiatry (Item 6.a.),
Vision (Item 6.b.),
Chiropractic (Item 6.c.),
Nurse practitioner (Item 6.d.E.),
Clinical nurse specialist (Item 6.d.H),
Medication therapy management (Item 6.d.I)
Audiology (Item 11.c.),
Nurse midwife (Item 17.).
Traditional midwife (Item 28)

S.1. Noted exceptions to clause S:

1. Procedure code 99000-99999 when performed by treating providers physician, nurse practitioner, nurse midwife, clinical nurse specialist, physician assistant and the pay-to-provider is a family planning agency
2. Procedure code 99201-99215, 99381-99412 when performed by treating provider specialties general practitioner, geriatric nurse practitioner, family nurse practitioner, geriatrician, family practitioner, or primary care.
3. 90281-90399, 90476-90749, G9142 (vaccines), 90465-90474 when provided with MN Vaccines for Children, 96372-96379 when provided with MN vaccines for Children, G9141 (administration), A4641-A4642, A9500-A9700, C9113-C9253, J0120-J9999, Q0144-Q0181, Q2004, Q2009, Q2017, Q3025-Q3026, Q4080-Q4099, Q9951-Q9967, S0012-S0197, S8085 (injections), S4989, S4993
4. G9002 (coordinated care fee),
5. S0280-S0281 (health care home)
6. S9441 UA, T1028 UA (asthma demo)

7. Teaching sites
8. Performance based payments
9. Administration of vaccines
10. Psychiatrist
11. Advanced practice nurses with a specialty in mental health
12. Mental health services provided through physicians
13. Anesthesia services

T.Rate increase July 1, 2010

Effective for services provided on or after July 1, 2010, the following provider payment rates for physicians' services are increased by one and one half percent:

Psychiatrists
Advanced practice nurses with a specialty in mental health (Items 5.a. and 6.d.)

U. Facility Services rate decrease 2009

Effective for services, except as noted in **U.1**, provided on or after July 1, 2009, the following services payment rates are reduced by 3 percent. Effective for services provided on or after July 1, 2009 and before July 1, 2011, the following services payment rates are reduced an additional one and one half percent:

Outpatient hospital (Item 2.a)
Renal dialysis (Item 2.a)
Laboratory (Item 3)
Public health nursing (except for pediatric vaccine administration as described in item ~~2~~5.a.)(item 6.d.B)
Medical supplies and durable medical equipment not subject to a volume purchase contract (Item 7.c)
Ambulatory surgery (Item 9.)
~~Noncontract~~ ~~c~~Eyeglasses and contact lenses not subject to a volume purchase contract (Item 12.d.)
~~Noncontract~~ ~~h~~Hearing aids not subject to a volume purchase contract (Item 11.c.)
Prosthetics and orthotics (Item 12.c.)

U.1. Noted exceptions to clause U:

1. For outpatient hospital exclude claim lines with [mental health] procedure codes 90800-90899, 96101-96103, 96118-96120, 97535 HE.
2. ~~For medical supplies and durable medical equipment exclude procedure codes E0424, E0431, E0434, E0439, E1390, S8120, S8121, K0738 (volume purchase oxygen) and E1399 with modifier QH. Effective 02/01/10, E0441-E0444, E1392~~
3. ~~For hearing aids, excluding claim lines priced using rates data and excluding procedure codes V5030, V5040, V5050, V5060, V5120, V5140, V5170, V5180, V5210, V5220, V5246, V5247, V5252,V5253, V5256, V5257, V5260, V5261 accompanied by a RB modifier.~~
4. Teaching sites

V. Facility and Professional Services rate increase 2010

Effective for services, except as noted in **V.1**, provided on or after July 1, 2010, the following services payment rates are increased by two percent:

Physical therapy (Item 11.a.)
Speech therapy (Item 11.c.)
Occupational therapy (Item 11.b.)

~~**V.1. Noted exceptions to clause V:**~~

~~1. For outpatient hospital exclude claim lines with [mental health] procedure codes 90800-90899, 96101-96103, 96118-96120, 97535 HE.~~
~~2. For medical supplies and durable medical equipment exclude procedure codes E0424, E0431, E0434, E0439, E1390, S8120, S8121, K0738 (volume purchase oxygen) and E1399 with modifier QH. Effective 02/01/10, E0441-E0444, E1392~~
~~3. For hearing aids, excluding claim lines priced using rates data and excluding procedure codes V5030, V5040, V5050, V5060, V5120, V5140, V5170, V5180, V5210, V5220, V5246, V5247, V5252,V5253, V5256, V5257, V5260, V5261 accompanied by a RB modifier.~~
4. ~~Teaching sites~~

W. Professional services rate decrease 2011

Effective for services provided on or after September 1, 2011, through June 30, 2013, the following services payment rates are reduced by 3 percent:

Radiology (Item 3)
Physician (Item 5.a)
Physician assistant (Item 5.a)
Podiatry (Item 6.a)
Optometrists' services (Item 6.b)
Chiropractic (Item 6.c)
Nurse practitioner (Item 6.d.E.)
Clinical nurse specialist (6.d.H)
Medication therapy management (Item 6.d.I)
Audiology (Item 11.c.)
Nurse midwife (Item 17)
Traditional midwife (Item 28)

X. Dental Services rate decrease 2011

Effective for services provided on or after September 1, 2011, through June 30, 2013, payment rates for dental services are reduced by 3% percent. (Item 10)

Y. Ambulance services rate decrease 2011

Effective for services provided on or after September 1, 2011, through June 30, 2016, payment rates for services are reduced by 4.5% percent. (Item 24.a.)

Z. Outpatient hospital facility rate decrease 2011

Effective for services provided on or after September 1, 2011, through June 30, 2013, payment rates for outpatient hospital facility fees are reduced by 5% percent. (item 2.a)

aa. Miscellaneous services and materials rate decrease 2011

Effective for services provided on or after September 1, 2011, through June 30, 2013, the following services payment rates are reduced by 3 percent:

ambulatory surgery centers facility fees (Item 9)
medical supplies and durable medical equipment not subject to a volume purchase contract (Item 7.c)
prosthetics and orthotics(Item 12.c)
renal dialysis services(Item 2.a)
laboratory services (Item 3)
public health nursing services (Item 6.d.B)
eyeglasses not subject to a volume purchase contract(Item12.d)
hearing aids not subject to a volume purchase contract(Item 7.c.)
anesthesia services (Item 5.a)
Physical therapy (Item 11.a.)
Speech therapy (Item 11.c)
Occupational therapy (Item 11.b)

bb. Reimbursement for costs of services provided by a non-state, government-operated community mental health center

Qualified physician, EPSDT and occupational therapy services provided by a non-state, governmental operated community mental health center, on or after September 1, 2011, are reimbursed for the actual incurred costs of providing services to eligible Medicaid beneficiaries. The non-state, governmental operated community mental health center must certify its expenditures as eligible for federal financial participation in order to settle to actual incurred costs for Medicaid services provided in the non-state, governmental operated community mental health center. The CMS approved Medicaid cost report entitled "Hennepin County Mental Health Center Cost Report" is due from the non-state, governmental operated community mental health center twelve months after the end of the provider's fiscal year, hereinafter referred to as the calendar year. An initial settlement will be processed within six months of receiving an approved cost report. A final settlement will be processed within twelve months of receiving the approved cost report. For the last quarter of calendar year 2011, and the entire calendar years 2012 and 2013, the final settlement will be processed in the fourth quarter ~~by February 1, 2012~~ of 2015. The payments will be paid to the non-state, governmental operated community mental health center in an amount based on the provider's reconciled costs for providing physician, EPSDT, and occupational therapy rehabilitative services to Medicaid recipients, less total payments for Medicaid covered services allowable elsewhere in Attachment 4.19-B, TPL payments, Medicare payments, and spenddown obligations. Reconciled costs will be calculated using CMS-approved cost reporting methods approved by the Department. The non-state, governmental operated community mental health center is required to comply with cost allocation principles found in OMB Circular A-87. For purposes of these payments, effective for services provided on or after September 1, 2011, costs shall be calculated as follows:

Costs will be calculated using the CMS-approved cost report on file with the Department for the cost report time period. The non-state, governmental operated community mental health center will submit the Hennepin County Mental Health Center cost report that is prepared in accordance with a cost reporting methodology developed by the office that complies with OMB Circular A-87. This cost report must be submitted to the office no later than the last day of the twelfth month following the provider's fiscal year end.
Payments will be the amounts calculated under Step Four of the following formula:

Step One: Determine the amount of the non-state, governmental operated community mental health center provider's charges for the eligible Medical Assistance procedure codes and Medical Assistance payment for claims for these codes incurred during the provider's fiscal year and adjudicated to a paid status through the MMIS.

bb. Reimbursement for costs of services provided by a non-state, government-operated community mental health center (cont'd)

Step Two: Determine the amount of the non-state, governmental operated community mental health center provider's reconciled costs for the provider's fiscal year for providing physician, EPSDT, occupational therapy rehabilitative services for Medical Assistance eligible persons. Cost for the provider's fiscal year will be calculated by multiplying the provider's charges for eligible CPT codes identified in Step One by the cost-to-charge ratio from the cost report on file with the Department corresponding to the fiscal year under consideration.

Step Three: Subtract the total Medicaid claims paid (including Medicare payments, spenddown obligations, and Third Party Liability) for the eligible procedure codes determined in Step One from the cost calculated in Step Two. If Medicaid reimbursement exceeds cost calculated in Step Two, an overpayment has been made. The Department will recover the overpayment in accordance with section 1903(d)(2) of the Social Security Act.

Step Four: If the amount calculated in Step Three is greater than zero, the provider will receive a payment equal to the amount calculated in Step Three multiplied by the Federal Medical Assistance Percentage (FMAP) rate for Minnesota in effect at the time of the payment.

cc. Supplemental payment for medical education

In addition to Medical Assistance payments included in this Attachment, Medical Assistance provides for an additional annual payment by April 30 of each year for the previous state fiscal year for distribution to Medical Assistance-enrolled qualified providers. A single pool of money equal to $7,575,000 is used to make supplemental payments to qualifying providers that include both non-institutional eligible training sites, and institutional eligible training sites described in Attachment 4.19-A Supplement 3. The Medical Assistance payment is increased in an amount equal to:

(1) $7,575,000, multiplied by a proportion equal to the qualifying provider's ~~hospital's~~ public program revenue divided by the total amount of public program revenue of all qualifying providers ~~eligible training sites~~. Public program revenue is the sum of a provider's revenue from medical assistance, prepaid medical assistance, and through June 30, 2014, general assistance medical care and prepaid general assistance medical care.

(2) For qualifying providers ~~hospitals~~ with public program revenue equal to or greater than 0.98 percent of the total public program revenue of all qualifying providers ~~eligible training sites~~, payments are increased by 20 percent.

(3) Payments to qualifying providers ~~training sites~~ with public program revenue less than 0.98 percent of the total public program revenue of all qualifying providers ~~eligible training sites~~ are reduced proportionately to fund the payment increases described in sub-item (2).

Effective July 1, 2015:

(4) Subitems (2) and (3) above no longer apply.

(5) Qualifying providers ~~Training sites~~ with no public program revenue, fewer than .1 FTE eligible trainees, or whose payment under subitem (1) would result in less than $5,000, are not eligible for increased payments.

(6) No qualifying provider shall receive a payment that is in excess of the 95th percentile for payment per FTE across all qualified providers. Excess payments shall be redistributed according to the formula above.

~~For State Fiscal Year 2013 only, the amount available in paragraph (1) above is $7,275,000, and prior to the formula in paragraphs (1) to (4), the annual payment to Gillette Children's Specialty Healthcare is increased by $300,000.~~

cc. Supplemental payment for medical education (cont'd)

Qualifying Provider. "Qualifying provider" means a Medical Assistance enrolled hospital, medical center, clinic, practitioner, or other organization that provides accredited clinical training of physicians (medical students and residents), doctor of pharmacy practitioners, doctors of chiropractic, dentists, advance practice nurses (clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), physician assistants, and effective July 1, 2015, dental therapists, advanced dental therapists, psychologists, clinical social workers, community paramedics, and community health workers; and that has successfully applied for this payment, in accordance with Minnesota Statutes § 62J.692.

~~**dd. Dental Services rate increase 2014**~~

~~Effective for services provided on or after January 1, 2014, payment rates for dental services shall be increased by five percent from the rates in effect on December 31, 2013. This increase does not apply to state-operated dental clinics, federally qualified health centers, rural health centers, Indian Health Service, and tribal 638 facilities.~~

ee. Rate decrease effective July 1, 2014

Effective for services provided on or after July 1, 2014, through June 30, 2015, payment for medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, is decreased by .33 percent. (Item c 7.c and 12.c.)

ff. Professional services rate increase effective September 1, 2014

Effective for services provided on or after September 1, 2014, the following service payment rates are increased by 5 percent from the rates in effect on August 31, 2014, except that the increase described in Section 1902(a)(13)(C) of the Act is not included in the August 31, 2014, base rate:

Physicians' services (Item 5.a)
Physical therapy services (Item 11.a)
Occupational therapy services (Item 11.b)
Speech pathology services (Item 11.c.)
Mental health services (Items 4.b., 6.d.A., 13.d.)

ff.1 Noted exceptions for clause ff:

1. For physicians' services, exclude procedure code S9986.
2. Assertive community treatment services in item 13.d.
3. Residential rehabilitative services in item 13.d.
4. Youth ACT services in item 4.b.

gg. Miscellaneous services and materials rate increase effective September 1, 2014

Effective for services provided on or after September 1, 2014, the following service payment rates are increased by 3 percent:

Ambulatory surgery center facility fees (Item 9)
Hospice services (Item 18)
Renal dialysis services (Item 2.a)
Outpatient hospital facility fees (2.a)
Laboratory services (Item 3)
Public health nursing services (Item 6.d.B)
Eyeglasses not subject to a volume purchase contract (Item 12.d)
Hearing aids not subject to a volume purchase contract (Item 7.c)

gg.1 Noted exceptions to clause gg:

1. For hospice services, exclude revenue code 0658.
   For outpatient hospital exclude [mental health] procedure codes 90800-90899, 96101-96103, 96118-96120, 97535 HE.

hh. Rate increase effective July 1, 2015

Effective for services provided on or after July 1, 2015, the following sequence of payment rate changes apply:

1. Payment is increased by 9.5 percent for medical supplies, durable medical equipment, prosthetics, and orthotics that were subject to Medicare's competitive bid process on January 1, 2009.
2. Payment is increased by 2.94 percent for medical supplies, durable medical equipment, prosthetics, and orthotics paid under the Medical Assistance fee schedule. This increase does not apply to durable medical equipment and supplies subject to a volume-purchase contract, certain diabetic testing supplies, items paid by report, and items provided to dually eligible individuals where Medicare is the primary payer.
3. Payment is increased by 3 percent for medical supplies and durable medical equipment, prosthetics, and orthotics. This increase does not apply to durable medical equipment and supplies subject to a volume-purchase contract, certain diabetic testing supplies, and items provided to dually eligible individuals where Medicare is the primary payer.

Effective for services provided on or after July 1, 2019, total reimbursement for items and services subject to the Medicare DME upper payment limit may not exceed the Medicare fee schedule rate. This limit does not apply to pressure support ventilators.

~~**ii. Dental Services rate increase 2015**~~

~~Effective for dental services provided by dental providers located outside of the seven-county metropolitan area on or after July 1, 2015, payment rates shall be increased by 9.65 percent from the rates in effect on June 30, 2015. This increase does not apply to state-operated dental clinics, federally qualified health centers, rural health centers, Indian Health Service, and tribal 638 facilities.~~

jj. Rate increase for miscellaneous services, effective July 1, 2015

Effective July 1, 2015, payment rates for the following services are increased 90 percent from the rates in effect on June 30, 2015, when provided by an essential community provider that was formerly a state hospital, and is now an outpatient hospital specializing in the treatment of cerebral palsy, spina bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling conditions:

Outpatient hospital facility fees (Item 2.a)
Medical supplies and durable medical equipment not subject to a volume purchase agreement (Item 7.c)
Physical therapy (Item 11.a)
Occupational therapy (Item 11.b)
Speech pathology (Item 11.c)
Prosthetics and orthotics (Item 12.c)

Payments made under this item are not limited by item H of this supplement.

kk. Ambulance services rate increase 2016

Effective for ambulance services provided on or after July 1, 2016, payment rates for services are increased by 5 percent for ambulance providers located within a municipality with a population of less than 1,000, or located outside the seven-county metro area and the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester.

mm. Dental Services rate increase 2022

Effective for services on or after January 1, 2022, payment rates for dental services shall be increased by ninety-eight percent. This increase does not apply to state-operated dental clinics, federally qualified health centers, rural health centers, the Indian Health Service, and tribal 638 facilities.

nn. Behavioral Health rate increase 2024.

Effective for services on or after January 1, 2024, payment rates for behavioral health services shall be increased by three percent from the rates in effect on December 31, 2023.

H0032	90882	
90882-HM	90882-U3	90882-U3-HM
H0031	H0031-TS	H0032-TS or H0032-Q2
H0034	H0034-HQ	H2017
H2017-HM	H2017-HQ	H2017-U3
H2017-U3-HM	90899-U8 or 90899-U8-HN	90899-U8-U4 or 90899-U8-U4-HN
90899-U9 or 90899-U9-HN	90899-U9-U4 or 90899-U9-U4-HN	90899-UB or 90899-UB-HN
90899-UB-U4 or 90899-UB-U4-HN	90899-UC or 90899-UC-HN	90899-UC-U4 or 90899-UC-U4-HN
H2027 or H2027-HN	H2027-HQ or H2027-HQ-HN	H2027-HQ-HR or H2027-HQ-HR-HN or H2027-HQ-HS or H2027-HQ-HS-HN
H2027-HR or H2027-HR-HN	H2027-HS or H2027-HS-HN	90832-UA
90833-UA	90834-UA	90836-UA
90837-UA	90838-UA	90839-UA
90840-UA	90846-UA	90847-UA
90849-UA	90853-UA	90875-UA
90876-UA	H0031-UA	H0032-UA
H2014-UA	H2014-UA-HQ	H2014-UA-HR
H2015-UA	H2019-UA	H2019-UA-HM
H2019-UA-HE	H2011	H2011-UA
H2011-HN	H2011-UA-HN	H2011-HM
H2011-HQ	90882-HK	90882-HK-HM
H2019-U1 or H2019-U1-HN	H2019-U1-HA or H2019-U1-HN-HA	H2019-U1-HQ or H2019-U1-HQ-HN
H2019-U1-HQ-HA or H2019-U1-HQ-HN-HA	90785	90791-52 or 90791-52-HN
90791 or 90791-HN	90791-TS or 90791-TS-HN	90792-52 or 90792-52-HN
90792 or 90792-HN	90792-TS or 90792-TS-	96116

	HN	
96121	96127	96132-96133
96136-96139	96146	H2012 UA HK
H0038	H0038-U5	H0038-HQ
99499-HE-AG	99499-HE-AM	90832-90834
90836-90840	H2012 HK	
90846-90847	90849	90853
90875-90876	90887 or 90887-HN	96130-96131
H0046	S0280 U5	S0281 U5
S5145 HE	S5145 HE HN	H2012 UA HK U6
H0035	HOO35 HA	

oo. MEI Adjustment for Behavioral Health Services

Effective January 1, 2025, all services included in section nn. above must be annually adjusted according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Medicare Economic Index (MEI).

1905(a)(29) Medication-Assisted Treatment (MAT)

Effective October 1, 2020 through December 31, 2025, ~~P~~payment methods and rates for MAT services provided in ~~opiate~~ Opioid ~~t~~Treatment ~~p~~Programs (OTP) ~~, licensed substance use disorder treatment programs, or by licensed professionals in private practice~~ are authorized under the 1905(a)(29) Medication-Assisted Treatment (MAT) ~~Rehabilitative Services (§ 13d.)~~ benefit in Attachment 4.19-B of the state plan. All enrolled OTP ~~SUD treatment~~ providers are reimbursed as described in this attachment. IHS and Tribal 638 facilities are reimbursed in accordance with Supplement 2 in this attachment.

Effective January 1, 2026, reimbursement for MAT services provided in OTP is the Minnesota-specific, locality-adjusted Medicare rate for OTP services. Payment rates are updated annually each January 1 for the full calendar year following the publication of the Medicare rates. OTPs are limited to the bundled rates for the provision of MAT services and drugs may not be billed separately. These rates do not apply to federally qualified health centers, rural health centers, certified community mental health centers, or IHS and Tribal 638 facilities. IHS and Tribal 638 facilities are reimbursed in accordance with Supplement 2 in this attachment.

Reimbursement for unbundled MAT prescribed drugs and biologicals used to treat opioid use ~~in~~ disorder in office based settings will be reimbursed using the same methodology as described for prescribed drugs in Attachment 4.19-B, Item 12a., ~~pages 37 through 37(d),~~ for prescribed drugs that are dispensed or administered by physician and non-physician practitioners.

Except as otherwise noted in the state plan, fee schedule rates are the same for both governmental and private providers. All rates are published at https://mn.gov/dhs/partners-and-providers/policies-procedures/minnesota-health-care-programs/provider/billing/fee-schedule/mhcp.jsp.

Methods and Standards for Establishing Payment Rates

Note: This section is left intentionally blank and has been deleted effective November 1, 2025

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☒	HCBS Personal Care

HCBS Personal Care Assistance payment under the agency-provider model with service unit allocation is the lower of the submitted charge, or the state agency established rate, up to the number of units authorized in the participant's approved service allocation:

Personal Care 1:1 unit $6.21

Personal Care 1:2 unit $4.67

Personal Care 1:3 unit $4.09

NOTE: One unit is equal to 15 minutes.

Participants receiving services under the agency-provider model who then transfer to the budget model, will have any remaining service units converted to a service budget as described above.

Shared care:

For two participants sharing services, payment is one and one-half times the payment for serving one participant. For three participants sharing services, payment must not exceed two times the payment for serving one participant. This paragraph applies only to situations in which all participants were present and received shared services on the date for which the service is billed.

The rate methodology consisted of:

• A base wage index was established using Minnesota-specific wages taken from job descriptions and standard occupational classification codes from the BLS Occupational Handbook.

• A competitive workforce factor multiplier was applied to the direct staffing wage to address the difference in average wages for direct care staff and other occupations with similar education, training, and experience requirements, as identified by the BLS Occupational Handbook.

• The average wages were adjusted to differentiate between shared and individual staffing.

• Shared staffing was taken into account, when staff are available to provide services to more than 1 person and individual staffing, when direct care staff are available to solely provide support as a 1-to-1 interaction with a specific individual.

• These wage expenses were multiplied by factors for relief staffing, ancillary staff needs, employee-related taxes and benefits, and client programming.

Budget Model:

Under the budget model, an amount equal to the participant's authorized service units multiplied by the amount listed above for a 1:1 unit is authorized for use by the participant.

Shared care: For 1:2 and 1:3 shared care under the budget model, services are billed according to the shared care rates outlined above.

Rate Enhancements

An enhanced rate of 107.5 percent of the rate paid for CFSS must be paid for services provided to persons who qualify for ten or more hours of CFSS per day when provided by a support worker who meets the training requirements.

A rate enhancement is also paid based on the experience of support workers according to the following formula (and applies to the 1:1, 1:2, and 1:3 rates). Workers must provide more than 1000 cumulative hours of PCA or CFSS services under sections 1905(a) for PCA, 1915(c) for extended PCA and extended CFSS, and under sections 1915(i) and 1915(k) for CFSS. The calculation is based on the cumulative hours worked beginning on July 1, 2017. When the 107.5% rate enhancement and the enhancement for worker experience applies to the same worker, the 107.5% amount is the base for calculating this additional enhancement.

The enhancement is as follows:

(1) for workers who have provided between 1,001 and 2,000 cumulative hours, the amount is 2.17 percent;

(2) for workers who have provided between 2,001 and 6,000 cumulative hours, the amount is 4.36 percent;

	(3) for workers who have provided between 6,001 and 10,000 cumulative hours, the amount is 7.35 percent; and (4) for workers who have provided more than 10,000 cumulative hours, the amount is 10.81 percent.
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☐	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
X	Other Services (specify below)
	Personal Emergency Response Systems (PERS): Personal emergency response systems include three parts. Each part has its own limit per service agreement year: • Purchase of the PERS equipment, including necessary training or instruction on use of the equipment ($1,500 maximum) • Installation, setup and testing of the PERS equipment ($500 maximum) • Monthly monitoring fees ($110 monthly maximum).

	The CFSS participant receives up to $3,000 total of personal emergency response equipment and related services per service agreement year.
	Individual Directed Goods and Services: When a participant chooses to purchase goods and services through CFSS, the cost for the goods and services is covered using the particpant's service budget. **Limitations:** Goods and Services must not exceed an individual's budget allocation.
	Financial Management Services: Financial Management Services (FMS) providers must provide their service rates to the state agency as a part of the contracting process. They are required to notify the state agency immediately of any changes to their established rates. FMS providers must make public the maximum rate(s) for their services and a public site with approved providers and rates is maintained by DHS at https://mn.gov/dhs/people-we-serve/people-with-disabilities/services/home-community/programs-and-services/fms.jsp. The rate and scope of FMS is negotiated between the participant or the participant's representative and the FMS provider, and included in the service delivery plan. FMS provider fees must be on a fee-for-service basis and not a percentage of the participants' service budget, and may not include set up fees, base rates or other similar charges.

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☒	HCBS Personal Care
	HCBS Personal Care Assistance payment under the agency-provider model with service unit allocation is the lower of the submitted charge, or the state agency established rate, up to the number of units authorized in the participant's approved service allocation: Personal Care 1:1 unit $6.21 Personal Care 1:2 unit $4.67 Personal Care 1:3 unit $4.09 NOTE: One unit is equal to 15 minutes. Participants receiving services under the agency-provider model who then transfer to the budget model, will have any remaining service units converted to a service budget as described above. Shared care: For two participants sharing services, payment is one and one-half times the payment for serving one participant. For three participants sharing services, payment must not exceed two times the payment for serving one participant. This paragraph applies only to situations in which all participants were present and received shared services on the date for which the service is billed. The rate methodology consisted of: • A base wage index was established using Minnesota-specific wages taken from job descriptions and standard occupational classification codes from the BLS Occupational Handbook.

• A competitive workforce factor multiplier was applied to the direct staffing wage to address the difference in average wages for direct care staff and other occupations with similar education, training, and experience requirements, as identified by the BLS Occupational Handbook.

• The average wages were adjusted to differentiate between shared and individual staffing.

• Shared staffing was taken into account, when staff are available to provide services to more than 1 person and individual staffing, when direct care staff are available to solely provide support as a 1-to-1 interaction with a specific individual.

• These wage expenses were multiplied by factors for relief staffing, ancillary staff needs, employee-related taxes and benefits, and client programming.

Budget Model:

Under the budget model, an amount equal to the participant's authorized service units multiplied by the amount listed above for a 1:1 unit is authorized for use by the participant.

Shared care: For 1:2 and 1:3 shared care under the budget model, services are billed according to the shared care rates outlined above.

Rate Enhancements

An enhanced rate of 107.5 percent of the rate paid for CFSS must be paid for services provided to persons who qualify for ten or more hours of CFSS per day when provided by a support worker who meets the training requirements.

A rate enhancement is also paid based on the experience of support workers according to the following formula (and applies to the 1:1, 1:2, and 1:3 rates). Workers must provide more than 1000 cumulative hours of PCA or CFSS services under sections 1905(a) for PCA, 1915(c) for extended PCA and extended CFSS, and under sections 1915(i) and 1915(k) for CFSS. The calculation is based on the cumulative hours worked beginning on July 1, 2017. When the 107.5% rate enhancement and the enhancement for worker experience applies to the same worker, the 107.5% amount is the base for calculating this additional enhancement.

The enhancement is as follows:

(1) for workers who have provided between 1,001 and 2,000 cumulative hours, the amount is 2.17 percent;

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	The CFSS participant receives up to $3,000 total of personal emergency response equipment and related services per service agreement year.
	Individual Directed Goods and Services: When a participant chooses to purchase goods and services through CFSS, the cost for the goods and services is covered using the particpant's service budget. **Limitations:** Goods and Services must not exceed an individual's budget allocation.
	Financial Management Services: Financial Management Services (FMS) providers must provide their service rates to the state agency as a part of the contracting process. They are required to notify the state agency immediately of any changes to their established rates. FMS providers must make public the maximum rate(s) for their services and a public site with approved providers and rates is maintained by DHS at https://mn.gov/dhs/people-we-serve/people-with-disabilities/services/home-community/programs-and-services/fms.jsp. The rate and scope of FMS is negotiated between the participant or the participant's representative and the FMS provider, and included in the service delivery plan. FMS provider fees must be on a fee-for-service basis and not a percentage of the participants' service budget, and may not include set up fees, base rates or other similar charges.

PAYMENT FOR RESERVED BED DAYS

Payment is made for leave days for hospital leave or therapeutic leave of a recipient who has not been discharged from the ICF/DD, psychiatric residential treatment facility (PRTF), or nursing facility (NF). A reserved bed must be held for a recipient on a hospital leave or therapeutic leave. Payment for leave days for recipients residing in a NF is equal to 30 percent of the nursing facility's total payment rate established for the applicable resident in accordance with Attachment 4.19-D. Payment for leave days for recipients residing in an ICF/DD is described in Attachment 4.19-D. Payment for leave days for recipients residing in a PRTF is described in Supplement 4 to Attachment 4.19-A.

Leave day definition. A leave day means any calendar day during which the recipient leaves the facility and is absent overnight, and all subsequent, consecutive calendar days. An overnight absence from the facility of less than 23 hours does not constitute a leave day. Nevertheless, if the recipient is absent from the facility to participate in active programming of the facility under the personal direction and observation of facility staff, the day shall not be considered a leave day regardless of the number of hours of the recipient's absences. For purposes of this definition, "calendar day" means the 24-hour period ending at midnight.

Reserved bed definition. A reserved bed means the same bed that a recipient occupied before leaving the facility for hospital leave or therapeutic leave, or an appropriately certified bed if the recipient's physical condition upon returning to the facility prohibits access to the bed he or she occupied before the leave.

Required occupancy rate. ICFs/DD with 25 or more licensed beds shall not receive payment for hospital leave days in a month for which the average occupancy rate of licensed beds is 93 percent or less. ICFs/DD with 24 or fewer licensed beds shall not receive payment for hospital leave days if a licensed bed has been vacant for 60 consecutive days prior to the first day of a hospital leave. NFs shall not receive payment for leave days in a month for which the average occupancy rate of licensed beds is less than 96 percent. For purposes of this paragraph, a reserved bed is not a vacant bed when determining occupancy rates and eligibility for payment of a leave day.

PAYMENT FOR RESERVED BED DAYS

Therapeutic leave days. A therapeutic leave is the absence of a recipient from an ICF/DD, a PRTF, or NF to (1) a camp meeting applicable licensure requirements of the Minnesota Department of Health, or (2) a residential setting other than a long-term care facility, a hospital, or other entity eligible to receive federal, state, or county funds to maintain a recipient, with the expectation that the recipient will return to the facility. Leave for a home visit or a vacation is a therapeutic leave.

The recipient's health record must document the date and time the recipient leaves the ICF/DD, PRTF, or NF and the date and time of return. The leave days must be reported on the invoice submitted by the ICF/DD, PRTF, or NF.

Coverage of therapeutic leave days is limited to:

- 36 days per calendar year for recipients receiving NF services.

- 72 days per calendar year for recipients receiving NF services in a facility licensed to provide services for the physically disabled.

- 72 days per calendar year for recipients receiving ICF/DD services. In addition, the Commissioner may approve up to 48 additional therapeutic Leave days if:
  - the recipient or the recipient's legal representative requests additional therapeutic leave days;
  - the case manager recommends that the leave is consistent with the goals of the recipient's individual service plan;
  - an evaluation by the case manager demonstrates that home and community based services and other alternative services are not feasible; and
  - all other state and federal requirements relating to therapeutic leave days are met.

- Three days per period of leave for recipients receiving services from a PRTF. The Commissioner may authorize additional leave days when medically appropriate.

PAYMENT FOR RESERVED BED DAYS

Hospital leave days. A hospital leave means the status of a recipient who has been transferred from the ICF/DD, PRTF, or NF to an inpatient hospital for medically necessary health care, with the expectation that the recipient will return to the ICF/DD, PRTF, or NF.

The recipient's health record must document the date and time the recipient was transferred to the hospital and the date and time of return to the ICF/DD, PRTF, or NF. The leave days must be reported on the invoice submitted by the ICF/DD, PRTF, or NF.

Coverage of hospital leave days for recipients residing in an ICF/DD or NF is limited to 18 consecutive days for each separate and distinct episode of medically necessary hospitalization. Coverage for recipients residing in a PRTF is limited to seven consecutive days for each separate and distinct episode. The Commissioner may authorize additional leave days when medically appropriate.

METHODS AND STANDARDS FOR DETERMINING PAYMENT RATES FOR SERVICES PROVIDED BY NURSING FACILITIES (NOT STATE GOVERNMENT-OWNED OR OPERATED)

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METHODS AND STANDARDS FOR DETERMINING PAYMENT RATES FOR SERVICES PROVIDED BY NURSING FACILITIES (NOT STATE-GOVERNMENT OWNED OR OPERATED)

SECTION 1.000 INTRODUCTIONS

SECTION 1.010 **General Purpose.** The purpose of the Minnesota Medicaid methods and standards for determining payment rates for nursing facilities, which are not owned or operated by the state, is to provide for payment of rates in conformity with applicable state and federal laws, regulations and quality and safety standards. In determining the rates, the Commissioner of the Department of Human Services will take into account the mix of resident needs, geographic location, and other factors. Minnesota has in place a public process which complies with the requirements of Section 1902(a) (13) (A) of the Social Security Act.

Through September 30, 2006, nursing facilities participating in the Minnesota Medical Assistance program could choose to be paid by the prospective rate-setting methodology described in Sections 1.000 to 21.000 or the contractual rate-setting methodology described in Section 22.000. Effective October 1, 2006, all nursing facilities were paid by the contractual rate-setting methodology described in Section 22.000. Effective October 1, 2008, nursing facilities are paid by a combination of the contractual rate-setting methodology in Section 22.000 and a new rebasing rate-setting methodology described in Section 23.000.

SECTION 1.020 Overview**.** A very brief description of the overall rate setting mechanism may be helpful. Cost reports are submitted annually. Nursing facilities have a common reporting year of October 1 to September 30. The rate year of October 1 to September 30, lags the report year by one year. The submitted cost reports are desk audited to determine allowable costs and then subject to various other cost category limitations. The rates that are set are subject to appeal. Rates may be adjusted retrospectively for field audit and appeal resolutions. Nursing facilities in

Minnesota cannot charge private paying residents rates which exceed the rate for medical assistance recipients receiving similar services in multiple bed rooms. The rate-setting systems can be summarized as follows:

A. **Care Related Costs Until July 1, 1999**

1. This type of cost is based on allowable care related costs from prior reporting years for each nursing facility. Only the nursing component varies with a resident's case mix.

2. Resident days and nursing care costs are adjusted using case mix weights to determine proportion of costs allocable to each of eleven payment classes.

3. There are eleven rates for each nursing facility based on the relative resource use and case mix needs of the resident.

4. Until July 1, 1999, homes are grouped by three geographic locations which set limits on rates. Special purpose or characteristic homes may be treated differently for purposes of applying rate limits.

5. Homes can also trade off nursing and other care related expenditures within the combined limits for those two cost categories. Beginning July 1, 1998, these two limitations do not apply, except for purposes of determining a facility’s efficiency incentive.

6. The care related costs include nursing salaries and supplies and non-prescription drugs.

7. The other care related costs include food costs, social services, activities etc.

B. **Overall Spending Limits Until July 1, 1999**

1. Pursuant to Section 11.047, the operating rate paid to a nursing facility will not be more than its prior year's allowed operating costs plus inflation plus a factor above inflation (on a per diem basis).

2. Pursuant to Section 11.047, a nursing facility determined to be high cost when compared to similar nursing facilities shall have its per diem costs reduced.

C. **Other Operating Costs Until July 1, 1999**

1. These costs are grouped by geographic location to set limits. Beginning July 1, 1998, nursing and other care related expenditures do not apply, except for purposes of determining a

facility's efficiency incentive. Similarly, the maintenance and administrative cost categories no longer apply.

2. There is an efficiency incentive. Homes can receive an additional payment if costs are under the Other Operating Cost limit.

3. The other operating costs include such costs as remaining dietary, laundry and linen, housekeeping, plant operations and maintenance, general and administrative, and the remaining payroll taxes and fringe benefits.

D. **Adjustment Factor**

1. Until July 1, 1999, all operating costs are updated annually by a 21 month inflation factor. The 21 month inflation factor accounts for the 9 month lag between the end of the reporting year (9/30) and the beginning of the rate year (the following 7/1). The Department contracts with an econometric firm to provide economic change indices for use in determining operation cost payment rates.

2. Until July 1, 1999, limits are established for a base year and are adjusted annually by a 12 month inflation index for the time period between the midpoints of cost reporting years. The process of indexing limits now extends to the overall spending limits.

3. Certain costs such as real estate taxes, special assessments, licensing fees, Public Employee Retirement Act pension contributions, and preadmission screening fees are passed through.

E. **Property Payment**

1. For the period July 1, 1992, to September 30, 1992, property rates continued as established under the current plan; that is, they will continue to be "frozen" with certain exceptions.

2. After September 30, 1992, a new property system took effect. That system establishes a minimum property rate equal to the greater of their current "frozen" property-related payment rate or $4.00 per resident day. This rate may be subject to adjustment due to several factors which include:

a. An incremental increase as determined utilizing the State's former rental system with certain modifications such as a higher equipment allowance, adding the actual cost of a major projects with the application of a limit on investment, or the sale of the nursing facility.

b. An equity incentive payment which will encourage equity rather than debt

financing of major projects. (effective 7/1/93)

c. A capital asset repair or replacement payment for purchases up to $150 per licensed bed per year with a carryover of any excess. (effective 7/1/93)

d. A refinancing incentive for a refinancing that saves on annual interest expense payments (effective 7/1/93).

3. For sales occurring before October 1, 2005, the sale of a nursing facility after June 30, 1992, may result in an increase in the nursing facility's property rate. The amount of that increase will be measured by the modified rental recalculation. An increase in interest expense is allowed within certain limitations. The amount of the "step-up" in the nursing facility's capital asset basis, if any, does not result in a property rate increase since depreciation is not a component of property rate computation.

4. After September 1, 1992, nursing facility appraisals will no longer be needed except to resolve appraisal appeals. The nursing facility's appraised value will be indexed for inflation annually. Also, capital asset additions or deletions will be deducted from the indexed appraised values.

F. **Contractual Rate-setting Alternative Method After August 1, 1995**

1. A nursing facility may apply to be paid a contractual alternative payment rate instead of the cost-based payment rate established under Sections 1.000 to 21.000. Proposal requirements, selection criteria, limits, exemptions, and consumer protections are described in Section 22.000.

2. A nursing facility electing to receive an alternative payment rate must enter into a contract with the Department. All contracts entered into are for a term not to exceed four years.

3. Different contract provisions may be negotiated for different facilities if required due to legislative changes or if negotiated based on facility proposals.

4. A nursing facility's case mix payment rates for the first rate year of a facility's contract is the payment rate the facility would have received under Sections 1.000 to 21.000.

5. Until July 1, 1999, a nursing facility's case mix payment rates for the second and subsequent years of a facility's contract are the previous rate year's contract payment rates plus an inflation adjustment.

6. A Medicare certified nursing facility electing to receive an alternative payment rate filing a Medicare cost report must comply with Section 22.080, item A. A nursing facility that is not Medicare certified does not have to file a Medicare cost report, but must file a cost report as

described in Section 2.000.

7. Certain other exemptions, such as an exemption from auditing requirements under applicable state laws, are outlined in Section 22.000.

8. Participation in the contractual alternative payment rate setting method is voluntary. Participating facilities must continue to comply with all state and federal requirements relating to quality assurances, vulnerable adults protections, residents' rights, and OBRA requirements.

G. Rebasing

Effective October 1, 2008, the nursing facility rate methodology was changed to phase in a new payment system. The rebasing law considers costs, establishes definitions, distinguishes between facility types and peer (or geographic) groups with consideration of facilities in different peer groups but in close proximity, sets limits on spending that can be recognized in the rates, incorporates new case mix indices, rewards efficiency, provides for pass-through of certain costs, and provides that the total payment rate will consist of operating, external fixed, and property payment rates. The new system will be phased in over eight years.

SECTION 1.030 **Definitions.**

Actual allowable historical operating cost. "Actual allowable historical operating cost" means the operating costs incurred by the nursing home and allowed by the Commissioner for the most recent reporting year.

Addition. "Addition" means an extension, enlargement, or expansion of the nursing home for the purpose of increasing the number of licensed beds or improving resident care.

Applicable credit. "Applicable credit" means a receipt or expense reduction as a result of a purchase discount, rebate, refund, allowance, public grant, beauty shop income, guest meals income, adjustment for overcharges, insurance claims settlement, recovered bad debts, or any other adjustment or income reducing the costs claimed by a nursing home.

Appraised value. "Appraised value" means the value of the nursing home buildings, attached fixtures, and land improvements used directly for resident care as determined under Section 17.000.

Assessment form. "Assessment form" means the form developed by the Department of Health as adopted and used for performing resident assessments.

Attached fixtures. "Attached fixtures" means equipment used directly for resident care affixed to the building and not easily movable as specified in the fixed equipment table of the depreciation

guidelines.

Buildings. "Buildings" means the physical plant used directly for resident care and licensed and auxiliary buildings in the nature of sheds, garages, and storage buildings located on the site if used directly for resident care. This definition does not include buildings or portions of buildings used by central, affiliated, or corporate offices.

Building capital allowance. "Building capital allowance" means the component of the property-related payment rate which is denominated as a payment for the use of building, attached fixtures, and land improvements.

Capital assets. "Capital assets" means a nursing home's buildings, attached fixtures, land improvements, depreciable equipment, leasehold improvements, and all additions to or replacements of those assets used directly for resident care.

Case mix operating costs. "Case mix operating costs" means the operating costs listed in Section 6.050 and the portion of fringe benefits and payroll taxes allocated to the nursing services cost category under Section 8.000.

Commenced construction. "Commenced construction" means the date on which a newly-constructed nursing home, or nursing home with an increase in licensed beds of 50 percent or more, meets all the following conditions:

A. The final working drawings and specifications were approved by the Commissioner of health.

B. The construction contracts were let.

C. A timely construction schedule was developed, stipulating dates for beginning, achieving various stages, and completing construction.

D. All zoning and building permits have been issued.

E. Financing for the project was secured as evidenced by the issuance of a binding letter of commitment by the financial institution, sale of bonds, or other similarly binding agreements.

Commissioner. "Commissioner" means the Commissioner of the Minnesota Department of Human Services.

Consulting agreement. means any agreement the purpose of which is for a central, affiliated, or corporate office to advise, counsel recommend, or suggest to the owner or operator of the nonrelated

long-term care facility measures and methods for improving the operation of the facility.

Cost category. "Cost category" means the classification or grouping of similar or related costs for purposes of reporting, audit, cost control, and the determination of cost limitations.

Cost report. "Cost report" means the document and supporting material specified by the Commissioner and prepared by the nursing home. The cost report includes the statistical, financial, and other relevant information for rate determination.

Deletion. "Deletion" means the sale, destruction, or dismantling of a nursing home capital asset or a portion of a nursing home capital asset without subsequent replacement.

Department. "Department" means the Minnesota Department of Human Services.

Depreciated replacement cost method. "Depreciated replacement cost method" means the method of property appraisal which determines the value of a capital asset by establishing the replacement cost new reduced by depreciation.

A. "Replacement cost new" means the amount required to obtain a new asset of equivalent utility to that which exists, but built at current prices, with modern materials and according to current standards, designs, and layout.

B. "Depreciation" means a loss of utility and hence value caused by deterioration or physical depreciation such as wear and tear, decay, dry rot, cracks, encrustations, or structural defects; and functional obsolescence such as poor plan, mechanical inadequacy or overadequacy, and functional inadequacy or overadequacy due to size, style, or age.

Depreciable equipment. "Depreciable equipment" means the standard movable care equipment and support service equipment generally used in nursing homes. Depreciable equipment includes that equipment specified in the major movable equipment table of the depreciation guidelines.

Depreciation guidelines. "Depreciation guidelines" means the most recent "The Estimated Useful Lives of Depreciable Hospital Assets," issued by the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois. Except as provided in Section 3.040, the useful lives in the depreciation guidelines must not be used in the determination of the total payment rate. The depreciation guidelines are incorporated by reference and are available for reference at the Minnesota State Law Library, Minnesota Judicial Center, 25 Constitution Avenue, Saint Paul, Minnesota, 55155.

Desk audit. "Desk audit" means the establishment of the payment rate based on the Commissioner's review and analysis of required reports, supporting documentation, and work sheets submitted by the

nursing home.

Direct cost. "Direct cost" means a cost that can be identified within a specific cost category without the use of allocation methods.

Discharge. "Discharge" means a termination of placement in the nursing home that is documented in the discharge summary signed by the physician. For the purposes of this definition, discharge does not include:

A. a transfer within the nursing home unless the transfer is to a different licensure level; or

B. a leave of absence from the nursing home for treatment, therapeutic, or personal purposes when the resident is expected to return to the same nursing home.

Equipment allowance. "Equipment allowance" means the component of the property-related payment rate which is denominated as a payment for the use of depreciable equipment.

Field audit. "Field audit" means the on-site examination, verification, and review of the financial records, statistical records, and related supporting documentation of the nursing home and any related organization.

Fringe benefits. "Fringe benefits" means workers' compensation insurance, group health or dental insurance, group life insurance, retirement benefits or plans, and an allowance for uniforms.

General and administrative costs. "General and administrative costs" means the costs of administering the nursing home as specified in Section 6.000.

Historical operating costs. "Historical operating costs" means the allowable operating costs incurred by the nursing home during the reporting year immediately preceding the rate year for which the payment rate becomes effective, after the Commissioner has reviewed those costs and determined them to be allowable costs under the medical assistance program, and after the Commissioner has applied the limit on general and administrative costs.

Hospital-attached nursing home. "Hospital-attached nursing home" means a nursing home which is: 1) under common ownership and operation with a licensed hospital and shares with the hospital the cost of common service areas such as nursing, dietary, housekeeping, laundry, plant operations, or administrative services; 2) is recognized by the Medicare Program as a hospital-based nursing facility; and 3) is required to use the stepdown method of allocation by the Medicare program, title XVIII of the Social Security Act, provided that the stepdown results in part of the cost of the shared areas to be allocated between the hospital and the nursing home, and that the stepdown numbers are

the numbers used for Medicare reimbursement, except that direct identification of costs to the nursing facility cost center will be permitted only when the comparable hospital costs have also been directly identified to a cost center which is not allocated to the nursing facility.

Indirect cost. "Indirect cost" means a cost that is incurred for a common or joint purpose and is identified with more than one cost category but is not readily identified with a specific cost category.

Land improvement. "Land improvement" means an improvement to the land surrounding the nursing home directly used for resident care as specified in the land improvements table of the depreciation guidelines, if replacement of the land improvement is the responsibility of the nursing home.

Management agreement. Is an agreement in which one or more of the following criteria exist:

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

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

C. The central, affiliated, or corporate office becomes or is required to become the licensee under applicable state law;

D. The agreement provides that the compensation for services provided under the agreement is directly related to any profits made by the facility;

E. The long-term care facility entering into the agreement is governed by a governing body that meets fewer than four times a year, that does not publish notice of its meetings, or that does not keep formal records of its proceedings.

Medical plan of care. "Medical plan of care" means documentation signed by the resident's physician which includes the resident's primary diagnoses, secondary diagnoses, orders for treatment

and medications, rehabilitation potential, rehabilitation procedures if ordered, clinical monitoring procedures, and discharge potential.

Moratorium exception: A "moratorium exception" results when nursing facilities are permitted to obtain licensure and medical assistance certification of new nursing home beds and construction projects that exceed the threshold in section 16.1374, item F. contingent upon appropriation of funds by the legislature. Appropriated funds are distributed through a competitive process. Rates for moratorium exception projects are determined as stated in section 22.061.

Necessary service. "Necessary service" means a function pertinent to the nursing home's operation which if not performed by the assigned individual would have required the nursing home to employ or assign another individual to perform it.

Nursing facility. "Nursing facility" means a facility licensed by the Department of Health as a Medical Assistance nursing home or a boarding care facility which meets federal certification requirements for a nursing facility.

Operating costs. "Operating costs" means the costs of operating the nursing home in compliance with licensure and certification standards. Operating cost categories are:

A. nursing, including nurses and nursing assistants training;

B. dietary;

C. laundry and linen;

D. housekeeping;

E. plant operation and maintenance;

F. other care-related services;

G. general and administrative;
H. payroll taxes, fringe benefits, and clerical training;

I. workers' compensation self-insurance;

J. group health, dental, or life insurance; and

K. real estate taxes and actual special assessments paid.

Other care-related operating costs. "Other care-related operating costs" means the operating costs listed in Section 6.060, and the portion of fringe benefits and payroll taxes allocated to the other care-related cost category, the cost of food, and the dietician consulting fees calculated under Section 8.000.

Other operating costs. "Other operating costs" means the operating costs listed in Sections 6.010-6.040 and 6.070, excluding the cost of food and dietician consulting fees, and the portion of fringe benefits and payroll taxes allocated to each of these operating costs categories under Section 8.000.

Payroll taxes. "Payroll taxes" means the employer's share of social security withholding taxes, governmentally required retirement contributions, and state and federal unemployment compensation taxes or costs.

Preopening costs. "Preopening costs" means the operating costs incurred prior to the admission of a resident to a newly-constructed nursing home.

Private paying resident. "Private paying resident" means a nursing home resident who is not a medical assistance program recipient for the date of service and whose payment rate is not established by another third party, including the Veterans Administration or Medicare.

Productive nursing hours. "Productive nursing hours" means all on-duty hours of nurses, aides, orderlies, and attendants. The on-duty hours of the director of nursing for facilities with more than 60 licensed beds and the on-duty hours of any medical records personnel are not included. Vacation, holidays, sick leave, classroom training, and lunches are not included in productive nursing hours.

Rate year. "Rate year" means the state of Minnesota's fiscal year for which a payment rate is effective, from July 1 through the following June 30. The July 1, 2004 rate year extends through September 30, 2005. As of October 1, 2005, “rate year” means October 1 through the following September 30.

Real estate taxes and special assessments. "Real estate taxes and special assessments" means the real estate tax liability shown on the annual property tax statement of the nursing home for the calendar year during which the rate year begins and the actual special assessments and related interest paid during the reporting year. The term does not include personnel costs or fees for late payment.

Related organization. "Related organization" means a person that furnishes goods or services to a nursing home and that is a close relative of a nursing home, an affiliate of a nursing home, a close relative of an affiliate of a nursing home, or an affiliate of a close relative of an affiliate of a nursing home.

A. An "affiliate" is 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. A "person" is an individual, a corporation, a partnership, an association, a trust, an unincorporated organization, or a government or political subdivision.

C. A "close relative of an affiliate of a nursing home" is an individual whose relationship by blood, marriage, or adoption to an individual who is an affiliate of a nursing home is no more remote than first cousin.

D. "Control" including the terms "controlling," "controlled by," and "under common control with" is 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.

Repair. "Repair" means the cost of labor and materials needed to restore an existing capital asset to sound condition after damage or malfunction or to maintain an existing capital asset in a usable condition.

Replacement. "Replacement" means a renovation or substitution of an existing capital asset to improve its function or extend its useful life.

Reporting year. "Reporting year" means the period from October 1 to September 30, immediately preceding the rate year, for which the nursing home submits its cost report, and which is the basis for the determination of the payment rate for the following rate year.

Resident day or actual resident day. "Resident day" or "actual resident day" means a day for which nursing services are rendered and billable, or a day for which a bed is held and billed.

Resident class. "Resident class" means each of the 11 categories established in Section 13.000.

Short length of stay facility. "Short length of stay facility" has the meaning given in Section 20.025.

Standardized resident days. "Standardized resident days" means the sum of the number of resident days in the nursing home in each resident class multiplied by the weight for that resident class.

Top management personnel. "Top management personnel" means owners, board members, corporate officers, general, regional, and district managers, administrators and the nursing home administrator, and any other person performing the function of such personnel. Persons performing functions only as nursing home department heads are not included in this definition.

Total payment rate. "Total payment rate" means the addition of the operating cost payment rate, the property-related payment rate, and the real estate tax and special assessments payment rate as established by the Commissioner to pay for the care of residents in nursing homes.

Useful life. "Useful life" means the length of time an asset is expected to provide economic service before needing replacement.

Utility vehicle. "Utility vehicle" means a vehicle specially equipped for purposes of nursing home operations and not readily adaptable to personal use.

Vested. "Vested" means the existence of a legally fixed unconditional right to a present or future benefit.

Working capital debt. "Working capital debt" means debt incurred to finance nursing home operating costs. Working capital debt does not include debt incurred to acquire or refinance a capital asset.

Working capital interest expense. "Working capital interest expense" means the interest expense incurred on working capital debt during the reporting year.

SECTION 2.000

SECTION 2.010
Treble Damages. Any vendor of medical care who willfully submits a cost report, rate application or claim for reimbursement for medical care which the vendor knows is false representation and which results in the payment of public funds for which the vendor is ineligible shall, in addition to other provisions of Minnesota law, be subject to an action by the State of Minnesota for civil damages. The damages awarded shall include three times the payments which result from the false representation, together with costs and disbursements, including reasonable attorneys' fees or their equivalent.

SECTION 3.000 COST ALLOCATION PROCEDURES

SECTION 3.010 **Classification.** Classification of costs is the process of charging costs to the appropriate cost categories and compiling a total for each cost category to be recorded on the cost report. Nursing facilities shall classify their costs in accordance with established cost categories. Costs that cannot be specifically classified in a cost category, such as the cost of generic supplies, must be classified in the general and administrative cost category.

SECTION 3.020 **Identification.** Except for the salary costs of individuals with multiple duties,

costs must be directly identified, without allocation, by routine classification of transactions when costs are recorded in the books and records of the nursing facility.

SECTION 3.030 **Personnel with multiple duties.** When a person other than top management personnel has multiple duties, the person's salary cost must be allocated to the cost categories on the basis of time distribution records that show actual time spent, or an accurate estimate of time spent on various activities. In a nursing facility of 60 or fewer beds, part of the salary or salaries of top management personnel may be allocated to other cost categories to the extent justified in time distribution records which show the actual time spent, or an accurate estimate of time spent on various activities. A nursing facility that chooses to estimate time spent must use a statistically valid method. Persons who serve in a dual capacity, including those who have only nominal top management responsibilities, shall directly identify their salaries to the appropriate cost categories. The salary of any person having more than nominal top management responsibilities must not be allocated.

SECTION 3.040 **Central, affiliated, or corporate office costs.** Cost allocation for central, affiliated, or corporate offices shall be governed by items A to F.

A. Central, affiliated, or corporate office costs representing services of consultants required by law or rule in areas including dietary, pharmacy, social services, or other resident care related activities may be allocated to the appropriate cost category, but only to the extent that those costs are directly identified by the nursing facility.

1. Definitions. For purposes of item B, the following have the meaning given them.

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

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

ii. The central, affiliated, or corporate office performs or is authorized to perform two or more of the following: the execution of contracts; authorization of purchase orders; signature authority for checks, notes, or other financial instruments; requiring the long-term care

facility to use the group or volume purchasing services of the central, affiliated, or corporate office; or the authority to make annual capital expenditures for the long-term care facility exceeding $50,000 or $500 per licensed bed, whichever is less, without first securing the approval of the long-term care facility board of directors;

iii. The central, affiliated, or corporate office becomes or is required to become the licensee under applicable state law;

iv. The agreement provides that the compensation for services provided under the agreement is directly related to any profits made by the long-term care facility; or

v. The long-term care facility entering into the agreement is governed by a governing body that meets fewer than four times a year, that does not publish notice of its meetings, or that does not keep formal records of its proceedings.

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

B. For rate years beginning on or after July 1, 1990, the central, affiliated or corporate office cost allocation in subitems (1) to (6) must be used when determining rates under Sections 1.000 through 22.000.

(1) All costs that can be directly identified with a specific nursing facility that is a related organization to the central, affiliated, or corporate office, or that is controlled by the central, affiliated, or corporate office under a management agreement, must be allocated to that nursing facility.

(2) All costs that can be directly identified with any other activity or function not described in subitem (1) must be allocated to that activity or function.

(3) Costs that have not been directly identified must be allocated to nursing facilities on a basis designed to equitably allocate the costs to the nursing facilities or activities receiving the benefits of the costs. This allocation must be made in a manner reasonably related to the services received by the nursing facilities. Where practical and when the amount is material, these costs must be allocated on a functional basis. The functions, or cost centers used to allocate central office costs, and the unit bases used to allocate the costs, including those central office costs allocated according to subitem 4, must be used consistently from one central office accounting period to another. If the central office wishes to change its allocation bases and believes the change will result in more appropriate and more accurate allocations, the central office must make a written request, with its

justification, to the commissioner for approval of the change no later than 120 days after the beginning of the central office accounting period to which the change is to apply. The commissioner's approval of a central office request will be furnished to the central office in writing. Where the commissioner approves the central office request, the change must be applied to the accounting period for which the request was made, and to all subsequent central office accounting periods unless the commissioner approves a subsequent request for change by the central office. The effective date of the change will be the beginning of the accounting period for which the request was made.

(4) After the costs that can be directly identified according to subitems (1) and (2) have been allocated, the remaining central, affiliated, or corporate office costs must be allocated between the nursing facility operations and other activities or facilities unrelated to the nursing facility operations based on the ratio of total operating costs, determined as follows:

a. The numerator for the allocation ratio shall be determined as follows:

i. For nursing facilities that are related organizations or are controlled by a central, affiliated, or corporate office under a management agreement, the numerator of the allocation ratio shall be equal to the sum of the total costs incurred by each related organization or controlled nursing facility.

ii. For a central, affiliated, or corporate office providing goods or services to related organizations that are not nursing facilities, the numerator of the allocation ratio shall be equal to the sum of the total costs incurred by the non-nursing facility related organizations.

iii. For a central, affiliated, or corporate office providing goods or services to unrelated nursing facilities under a consulting agreement, the numerator of the allocation ratio shall be equal to the greater of directly identified central affiliated or corporate costs or the contracted amount.

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

b. The denominator for the allocation ratio is the sum of the numerators in clauses i to iv of a.

(5) Those long term care operations that have nursing facilities both in Minnesota and outside of Minnesota must:

a. Allocate the nursing facility operation's central, affiliated or corporate office costs

identified in item C to Minnesota based on the ratio of total resident days in Minnesota nursing facilities to the total resident days in all facilities.

b. Allocate the Minnesota nursing facility operation's central, affiliated or corporate office costs identified in a to each Minnesota nursing facility on the basis of resident days.

(6) This section does not apply to payment rates determined under Section 20.040, except that any additional directly identified costs associated with the Department of Human Services' or the Department of Health's managing agent under a receivership agreement must be allocated to the facility under receivership, and are nonallowable costs to the managing agent on the facility's cost report.

C. Central, affiliated, or corporate office property-related costs of capital assets used directly by the nursing facility in the provision of nursing facility services must be allocated to the nursing facilities which use the capital asset. Central, affiliated, or corporate office property-related costs of capital assets which are not used directly by the nursing facility in the provision of nursing facility services must be allocated to the general and administrative cost category of each nursing facility using the methods described in item B.

D. The useful life of a new capital asset maintained by a central, affiliated, or corporate office must be determined by applying one of the following schedules in subitem (1) or (2):

(1) the useful life of a building is 35 years; of land improvement is 20 years; of a major building improvement is the greater of 15 years or the remaining life of the principal capital asset; of depreciable equipment except vehicles is ten years; and of a vehicle is four years; or

(2) the depreciation guidelines.

E. The useful life of used capital assets maintained by a central, affiliated, or corporate office must be determined based on the physical condition of the used capital asset but the useful life of the used capital asset must not be less than one-half the useful life determined under item D.

F. The useful life of leasehold improvements maintained by a central, affiliated, or corporate office must be either the useful life of the improvement determined under item D or the remaining term of the lease, including renewal periods, whichever is shorter.

SECTION 3.050 **General and administrative costs.** Except as provided above, general and administrative costs must not be allocated as direct or indirect costs to other cost categories.

SECTION 3.060 **Related organization costs.** Costs applicable to services, capital assets, and supplies directly or indirectly furnished to the nursing facility by any related organization may be

included in the allowable cost of the nursing facility at the purchase price paid by the related organization for capital assets or supplies and at the cost incurred by the related organization for the provision of services to the nursing facility if these prices or costs do not exceed the price of comparable services, capital assets, or supplies that could be purchased elsewhere. For this purpose, the related organization's costs must not include an amount for markup or profit.

If the related organization in the normal course of business sells services, capital assets, or supplies to nonrelated organizations, the cost to the nursing facility shall be the nonrelated organization's price provided that sales to nonrelated organizations constitute at least 50 percent of total annual sales of similar services, or capital assets, or supplies. The cost of ownership of a capital asset which is used by the nursing facility must be included in the allowable cost of the nursing facility even though it is owned by a related organization.

SECTION 4.000 DETERMINATION OF ALLOWABLE COSTS

SECTION 4.010 **Allowable costs.** Only costs determined to be allowable under the methods used to determine payment shall be used to compute the total payment rate for nursing facilities participating in the medical assistance program.

SECTION 4.020 **Applicable credits.** Applicable credits must be used to offset or reduce the expenses of the nursing facility to the extent that the cost to which the credits apply was claimed as a nursing facility cost. Interest income, dividend income, and other investment income of the nursing facility or related organization are not applicable credits except to the extent that the interest expense on working capital debt is incurred and claimed as a reimbursable expense by the nursing facility or related organization. Interest income must not be offset against working capital interest expense if it relates to a bond sinking fund or a restricted fund if the income is not available to the nursing facility or related organization. Gains or losses on the sales of capital assets used by the nursing facility must not be applicable credits.

SECTION 4.030 **Adequate documentation.** A nursing facility shall keep adequate documentation.

A. In order to be adequate, documentation must:

(1) Be maintained in orderly, well-organized files.

(2) Not include documentation of more than one nursing facility in one set of files unless transactions may be traced by the Department to the nursing facility's annual cost report.

(3) Include a paid invoice or copy of a paid invoice with date of purchase, vendor name and address, purchaser name and delivery destination address, listing of items or services purchased, cost of items purchased, account number to which the cost is posted, and a breakdown of any allocation of costs between accounts or nursing facilities. If any of the information is not available,

the nursing facility shall document its good faith attempt to obtain the information.

(4) Include contracts, agreements, amortization schedules, mortgages, other debt instruments, and all other documents necessary to explain the nursing facility's costs or revenues.

(5) Be retained by the nursing facility to support the five most recent annual cost reports. The Department may extend the period of retention if the field audit was postponed because of inadequate record keeping or accounting practices, the records are necessary to resolve a pending appeal, or are required for the enforcement of Minnesota's conditions for participation.

(6) Beginning July 1, 1998, payroll records supporting compensation costs claimed by long-term care facilities must be supported by affirmative time and attendance records prepared by each individual at intervals of not more than one month. The requirements of this subitem are met when documentation is provided under either clause a or b as follows:

a. the affirmative time and attendance record must identify the individual's name; the days worked during each pay period; the number of hours worked each day; and the number of hours taken each day by the individual for vacation, sick, and other leave. The affirmative time and attendance record must include a signed verification by the individual and the individual's supervisor, if any, that the entries reported on the record are correct; or

b. if the affirmative time and attendance records identifying the individual’s name, the days worked each pay period, the number of hours worked each day, and the number of hours taken each day by the individual for vacation, sick, and other leave are placed on microfilm, equipment must be made available for viewing and printing them, or if the records are stored as automated data, summary data must be available for viewing and printing.

B. Compensation for personal services, regardless of whether treated as direct or indirect costs, must be documented on payroll records. Payrolls must be supported by time and attendance or equivalent records for individual employees. Salaries and wages of employees which are allocated to more than one cost category must be supported by time distribution records. The method used must produce a proportional distribution of actual time spent, or an accurate estimate of time spent performing assigned duties. The nursing facility that chooses to estimate time spent must use a statistically valid method. The compensation must reflect an amount proportionate to a full-time basis if the services are rendered on less than a full-time basis.

C. Except for vehicles used exclusively for nursing facility business, the nursing facility or related organization must maintain a motor vehicle log that shows nursing facility mileage for the reporting year. Mileage paid for the use of a personal vehicle must be documented.

D. Complete and orderly records must be maintained for cost allocations made to cost

categories.

E. If the Commissioner requests supporting documentation during an audit for an item of cost reported by a long-term care facility, and the long-term care facility's response does not adequately document the item of cost, the Commissioner may make reasoned assumptions considered appropriate in the absence of the requested documentation to reasonably establish a payment rate rather than disallow the entire item of cost. This provision shall not diminish the long-term care facility's appeal rights.

SECTION 4.040 **Compensation for personal services.** Compensation for personal services includes all the remuneration paid currently, accrued or deferred, for services rendered by the nursing facility's owners or employees. Only valid compensation costs for the current reporting period are allowable.

A. Compensation includes:

(1) salaries, wages, bonuses, vested vacations, vested sick leave, and fringe benefits paid for managerial, administrative, professional, and other services;

(2) amounts paid by the nursing facility for the personal benefit of the owners or employees;

(3) the costs of assets and services which the owner or employee receives from the nursing facility;

(4) deferred compensation, individual retirement plans such as individual retirement accounts, pension plans, and profit-sharing plans;

(5) the annual cost of supplies, use of capital assets, services for personal use, or any other in-kind benefits received by the owners or employees; and

(6) payment to organizations of unpaid workers, that have arrangements with the nursing facility for the performance of services by the unpaid workers.

B. The nursing facility must have a written policy for payment of compensation for personal services. The policy must relate the individual's compensation to the performance of specified duties and to the number of hours worked. Compensation payable under the plan must be consistent with the compensation paid to persons performing similar duties in the nursing facility industry. Employees covered by collective bargaining agreements are not required to be covered by the policy if the collective bargaining agreement otherwise meets the
essentials of the policy required by this item.

C. Only necessary services shall be compensated.

D. Except for accrued vested vacation, accrued vested sick leave, or compensation claims subject to litigation or employer-employee dispute resolution, compensation must be actually paid, whether by cash or negotiable instrument, within 107 days after the close of the reporting period. If payment is not made within 107 days, the unpaid compensation shall be disallowed in that reporting year.

SECTION 4.050 **Licensure and certification costs.** Operating costs of meeting the licensure and certification standards in items A to C are allowable operating costs for the purpose of setting nursing facility payment rates. The standards are:

A. standards set by federal regulations for skilled nursing facilities and intermediate care facilities;

B. requirements established by the Minnesota Department of Health for meeting health standards as set out by state rules and federal regulations; and

C. other requirements for licensing under state and federal law, state rules, or federal regulations that must be met to provide nursing and boarding care services.

SECTION 4.060 **Routine service costs.** Operating costs of routine services including nursing, dietary, and support services are allowable operating costs for the purpose of setting nursing facility payment rates.

SECTION 4.080 **General cost principles.** For rate-setting purposes, a cost must satisfy the following criteria:

A. the cost is ordinary, necessary, and related to resident care;

B. the cost is what a prudent and cost conscious business person would pay for the specific good or service in the open market in an arm's length transaction;

C. the cost is for goods or services actually provided in the nursing facility;

D. the cost effects of transactions that have the effect of circumventing these rules are not allowable under the principle that the substance of the transaction shall prevail over form; and

E. costs that are incurred due to management inefficiency, unnecessary care or facilities,

agreements not to compete, or activities not commonly accepted in the nursing facility care field are not allowable.

SECTION 5.000 NONALLOWABLE COSTS

The costs listed in items A to EE are not allowable for purposes of setting payment rates but must be identified on the nursing facility's cost report.

A. All contributions, including charitable contributions, and contributions to political action committees or campaigns.

B. Salaries and expenses of a lobbyist.

C. Legal and related expenses for unsuccessful challenges to decisions by governmental agencies.

D. Assessments made by or the portion of dues charged by associations or professional organizations for litigation except for successful challenges to decisions by agencies of the State of Minnesota; lobbying costs; or contributions to political action committees or campaigns. Where the breakdown of dues charged to a nursing facility is not provided, the entire cost shall be disallowed.

E. Advertising designed to encourage potential residents to select a particular nursing facility. This item does not apply to a total expenditure of $2,000 for all notices placed in the telephone yellow pages for the purpose of stating the nursing facility's name, location, phone number, and general information about services in the nursing facility.

F. Assessments levied by the Minnesota Department of Health for uncorrected violations.

G. Employee or owner's membership or other fees for social, fraternal, sports, health, or similar organizations.

H. Cost incurred for activities directly related to influencing employees with respect to unionization.

I. Costs of activities not related to resident care such as flowers or gifts for employees or owners, employee parties, and business meals except for the cost of meals incurred as a result of required overnight business related travel.

J. Costs related to purchase of and care for pets in excess of $5 per year per licensed bed.

K. Penalties including interest charged on the penalty, interest charges which result from an

overpayment, and bank overdraft or late payment charges.

L. Costs of sponsoring employee, youth, or adult activities such as athletic teams and beauty contests.

M. Premiums on owner's or board member's life insurance policies, except that such premiums shall be allowed if the policy is included within a group policy provided for all employees, or if such a policy is required as a condition of mortgage or loan and the mortgagee or lending institution is listed as the beneficiary.

N. Personal expenses of owners and employees, such as vacations, boats, airplanes, personal travel or vehicles, and entertainment.

O. Costs of training programs for anyone other than employees or volunteers in the nursing facility.

P. Costs of training programs to meet the minimum educational requirements of a position, education that leads to a degree, or education that qualifies the employee for a new trade or profession. This item does not apply to training or education of nursing aides or training to meet the requirements of laws, rules, or regulations for keeping an employee's salary, status, or position or to maintain or update skills needed in performing the employee's present duties.

Q. Bad debts and related bad debt collection fees except for the four types found in the general and administrative services section.

R. Costs of fund raising activities.

S. Costs associated with the management of investments which may produce interest income, dividend income, or other investment income or losses.

T. Costs of functions normally paid by charges to residents, employees, visitors, or others such as the direct and indirect costs of operating a pharmacy, congregate dining program, home delivered meals program, gift shop, coffee shop, apartment, or day care center.

U. Operating costs for activities to the extent that the activities are financed by gifts or grants from public funds. A transfer of funds from a local governmental unit to its governmental-owned nursing facility is not a gift or grant under this item.

V. Telephone, television, and radio service provided in a resident's room except for these services provided in areas designated for use by the general resident population, and the charge of transferring a resident's phone from one room to another within the same nursing facility.

W. Costs of covenants not to compete.

X. Identifiable costs of services provided by a licensed medical therapeutic or rehabilitation practitioner or any other vendor of medical care which are billed separately on a fee for service basis, including:

(1) the purchase of service fees paid to the vendor or his or her agent who is not an employee of the nursing facility or the compensation of the practitioner who is an employee of the nursing facility;

(2) allocated compensation and related costs of any nursing facility personnel assisting in providing these services; and

(3) allocated operating or property cost for providing these services such as housekeeping, laundry, maintenance, medical records, payroll taxes, space, utilities, equipment, supplies, bookkeeping, secretarial, insurance, supervision and administration, and real estate taxes and special assessments.

If any of the costs in subitems (1) to (3) are incurred by the nursing facility, these costs must be reported as nonreimbursable expenses, together with any of the income received or anticipated by the nursing facility including any charges by the nursing facility to the vendor.

Y. Costs for which adequate documentation is not maintained or provided.

Z. Fringe benefits or payroll taxes associated with disallowed salary costs.

AA. Costs associated with sales or reorganizations of nursing facilities.

BB. Accruals of vacation and sick leave for employees which are not fully vested.

CC. Payments made in lieu of real estate taxes, unless such payments are made under a legally enforceable irrevocable written contract entered into prior to August 31, 1983.

DD. Adverse judgments, settlements, and repayments of escrow accounts resulting from the enforcement of Minnesota's Conditions for Participation Statute.

EE. Costs including legal fees, accounting fees, administrative costs, travel costs, and the costs of feasibility studies attributed to the negotiation or settlement of a sale or purchase of any capital asset by acquisition or merger for which any payment has previously been made under Minnesota's procedures for determining payment rates.

SECTION 6.000 REPORTING BY COST CATEGORY

SECTION 6.010 **Dietary services.** The costs listed in items A to D are to be reported in the dietary services cost category:

A. Direct costs of normal and special diet food including raw food, dietary supplies, food preparation and serving, and special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as a prescription item by a physician;

B. The salaries and wages of the supervisor, dietitians, chefs, cooks, dishwashers, and other employees assigned to the kitchen and dining room including the salaries or fees of dietary consultants;

C. The costs of training including the cost of lodging and meals to meet the requirements of laws, rules, or regulations for keeping an employee's salary, status, or position or to maintain or update skills needed in performing the employee's present duties; and

D. The costs of travel necessary for training programs for dietitians required to maintain licensure, certification, or professional standards.

SECTION 6.020 **Laundry and linen services.** The costs listed in items A and B are to be reported in the laundry and linen services cost category:

A. Direct costs of housekeeping supplies, including cleaning and lavatory supplies; and

B. The salaries and wages of the supervisor, housekeepers, and other cleaning personnel.

SECTION 6.030 **Housekeeping services.** The costs listed in items A and B are to be reported in the housekeeping services cost category:

A. Direct costs of housekeeping supplies, including cleaning and lavatory supplies; and

B. The salaries and wages of the supervisor, housekeepers, and other cleaning personnel.

SECTION 6.040 **Plant operation and maintenance services.** The costs listed in items A to D are to be reported in the plant operations and maintenance cost category:

A. Direct costs for maintenance and operation of the building and grounds, including fuel, electricity, water, sewer, supplies, tools, and repairs which are not capitalized;

B. The salaries and wages of the supervisor, engineers, heating-plant employees, independent contractors, and other maintenance personnel:

C. The cost of required licenses and permits required for operation of the nursing facility: and

D. Cost of the provider surcharge.

SECTION 6.050 **Nursing services.** Direct costs associated with nursing services identified in items A to Y, are to be included in the nursing services cost category:

A. Nursing assessment of the health status of the resident and planning of appropriate interventions to overcome identified problems and maximize resident strengths;

B. Bedside care and services;

C. Care and services according to the order of the attending physicians;

D. Monitoring procedures such as vital signs, urine testing, weight, intake and output, and observation of the body system;

E. Administration of oral, sublingual, rectal, and local medications topically applied, and appropriate recording of the resident's responses;

F. Drawing blood and collecting specimens for submission to laboratories;

G. Prevention of skin irritation and decubitus ulcers;

H. Routine changing of dressings;

I. Training, assistance, and encouragement for self-care as required for feeding, grooming, ambulation, toilet, and other activities of daily living including movement within the nursing facility;

J. Supportive assistance and training in resident transfer techniques including transfer from bed to wheelchair or wheelchair to commode;

K. Care of residents with casts, braces, splints, and other appliances requiring nursing care or supervision;

L. Care of residents with behavior problems and severe emotional problems requiring nursing care or supervision;

M. Administration of oxygen;

N. Use of nebulizers;

O. Maintenance care of resident's colostomy, ileostomy, and urostomy;

P. Administration of parenteral medications, including intravenous solutions;

Q. Administration of tube feedings;

R. Nasopharyngeal aspiration required for maintenance of a clean airway;

S. Care of suprapubic catheters and urethral catheters;

T. Care of tracheostomy, gastrostomy, and other tubes in a body;

U. Costs of equipment and supplies that are used to complement the services in the nursing services cost category, including items stocked at nursing stations or on the floor and distributed or used individually, including: alcohol, applicators, cotton balls, incontinence pads, disposable ice bags, dressings, bandages, water pitchers, tongue depressors, disposable gloves, enemas, enema equipment, soap and water, medication cups, diapers, plastic waste bags, sanitary products, thermometers, hypodermic needles and syringes, and clinical reagents or similar diagnostic agents, and drugs which are not paid on a separate fee schedule by the medical assistance program or any other payer;

V. Costs for education or training including the cost of lodging and meals of nursing service personnel. Educational costs are limited to either meeting the requirements of laws or rules or keeping an employee's salary, status, or position or for maintaining or updating skills needed in performing the employee's present duties, except that training to become a nurses aid is an allowable cost;

W. The salaries and wages of persons performing nursing services including salaries of the director, and assistant director of nursing, supervising nurses, medical records personnel, registered professional nurses, licensed practical nurses, nurses aides, orderlies, and attendants;

X. The salaries of fees of medical director, physicians, or other professionals performing consulting services on medical care which are not reimbursed separately on a fee for service basis; and

Y. The costs of travel necessary for training programs for nursing personnel required to

maintain licensure, certification, or professional standards.

SECTION 6.060 **Other care-related services.** The costs listed in items A to D are to be reported in the other care-related services cost category:

A. Direct costs of other care-related services, such as recreational or religious activities, arts and crafts, pets, and social services which are not reimbursed separately on a fee for service basis;

B. The salaries and wages of recreational therapists and aides, rehabilitation therapists and aides, chaplains, arts and crafts instructors and aides, social workers and aides, and other care-related personnel including salaries or fees of professional performing consultation services in these areas which are not reimbursed separately on a fee for service basis;

C. The costs of training including the cost of lodging and meals to meet the requirements of laws or rules for keeping an employee's salary, status, or position, or to maintain or update skills needed in performing the employee's present duties; and

D. Telephone, television, and radio services provided in areas designated for use by the general resident population, such as lounges and recreation rooms and the charge of transferring a resident's phone from one room to another within the same nursing facility.

SECTION 6.070 **General and administrative services.** Direct costs for administering the overall activities of the nursing facility are included in the general and administrative cost category. These direct costs include:

A. Business office functions;

B. Travel expenses other than travel expenses reported under dietary services and those under nursing services.

C. All motor vehicle operating expenses;

D. Telephone and telegraph charges;

E. Office supplies;

F. Insurance, except as included as a fringe benefit;

G. Personnel recruitment costs including help wanted advertising;

H. The salaries, wages, or fees of administrators, assistant administrators, accounting and clerical personnel, data processing personnel, and receptionists;

I. Professional fees for services such as legal, accounting, and data processing services;

J. Management fees, and the cost of management and administrative consultants;

K. Central, affiliated, or corporate office costs excluding the cost of depreciable equipment used by individual nursing facilities which are included in the computation of the property-related payment rate and those costs specified in Section 3.040, items A and B;

L. Business meetings and seminars;

M. Postage;

N. Training including the cost of lodging and meals for management personnel and personnel not related to direct resident care if the training either meets the requirements of laws, rules, or regulations to keep an employee's salary, status, or position or maintains or updates skills needed to perform the employee's present duties;

O. Membership fees for associations and professional organizations which are directly related to resident care;

P. Subscriptions to periodicals which are directly related to the operation of the nursing facility;

Q. Security services or security personnel;

R. Joint commission on accreditation of hospitals survey;

S. Advertising;

T. Board of director's fees;

U. Interest on working capital debt;

V. Bad debts and fees paid for collection of bad debts provided that the conditions in subitems (1) to (4) are met:

(1) the bad debt results from nonpayment of the payment rate or part of the payment rate;

(2) the nursing facility documents that reasonable collection efforts have been made, the

debt was uncollectible, and there is no likelihood of future recovery;

(3) the collection fee does not exceed the amount of the bad debt; and

(4) the debt does not result from the nursing facility's failure to comply with federal and state laws, state rules, and federal regulations.

W. The portion of preopening costs capitalized as a deferred charge and amortized over a period of 120 consecutive months beginning with the month in which a resident first resides in a newly-constructed nursing facility;

X. The cost of meals incurred as a result of required overnight business related travel; and

Y. Any costs which cannot be specifically classified to another cost category.

SECTION 6.080 **Payroll taxes, fringe benefits, and clerical training.** Only the costs identified in items A to I are to be reported in the payroll taxes, fringe benefits, and clerical training cost category;

A. The employer's share of the social security withholding tax;

B. State and federal unemployment compensation taxes or costs;

C. Group life insurance;

D. Group health and dental insurance;

E. Workers' compensation insurance including self-insured plans specified in Section 6.083;

F. Either a pension plan or profit-sharing plan, approved by the United States Internal Revenue Service including IRS Section 403 (b) and 408 (k), but not both for the same employee;

G. Governmental required retirement contributions;

H. Uniform allowance; and

I. Costs of training clerical personnel including the cost of meals and lodging.

SECTION 6.083 **Workers compensation self-insurance.** The Department shall allow as workers' compensation insurance costs the costs of workers' compensation coverage obtained under the following conditions:

A. A plan approved by the Commissioner of commerce as a Minnesota group or individual self-insurance plan.

B. A plan in which:

(1) The nursing facility, directly or indirectly, purchases workers' compensation coverage from an authorized insurance carrier;

(2) A related organization to the nursing facility reinsures the workers' compensation coverage purchased, directly or indirectly, by the nursing facility; and

(3) All of the conditions in item D are met;

C. A plan in which:

(1) the nursing facility, directly or indirectly, purchases workers' compensation coverage from an authorized insurance carrier;

(2) the insurance premium is calculated retrospectively, including a maximum premium limit, and paid using the paid loss retro method; and

(3) all of the conditions in item D are met ;

D. Additional conditions are:

(1) the costs of the plan are allowable under the federal Medicare program;

(2) the reserves for the plan are maintained in an account controlled and administered by a person which is not a related organization to the nursing facility;

(3) the reserves for the plan cannot be used, directly or indirectly, as collateral for debts incurred or other obligations of the nursing facility or related organizations to the nursing facility;

(4) if the plan provides workers' compensation coverage for non-Minnesota nursing facilities, the plan's cost methodology must be consistent among all nursing facilities covered by the plan, and if reasonable, is allowed notwithstanding any reimbursement laws regarding cost allocation to the contrary;

(5) central, affiliated, corporate, or nursing facility costs related to their administration of the plan are costs which must remain in the nursing facility's administrative cost category and must not be allocated to other cost categories;

(6) required security deposits, whether in the form of cash, investments, securities, assets, letters of credit, or in any other form are not allowable costs for purposes of establishing the facilities payment rate; and

(7) for the rate year beginning on July 1, 1998, a group of nursing facilities related by common ownership that self-insures workers' compensation may allocate its directly identified costs of self-insuring its Minnesota nursing facility workers among those nursing facilities in the group that are paid under this section or Section 22.000. The method of cost allocation is based on the ratio of each nursing facility's total allowable salaries and wages to that of the nursing facility group's total allowable salaries and wages, then similarly allocated within each nursing facility's operated cost categories. The costs associated with the administration of the group's self-insurance plan must remain classified in the nursing facility's administrative cost category. A written request of the nursing facility group's election to use this alternative method of allocation of self-insurance costs must have been received by the Department no later than May 1, 1998, to take effect on July 1, 1998, or such costs will continue to be allocated under the existing cost allocation methods. Once a nursing facility group elects this method of cost allocation for its workers' compensation self-insurance costs, it remains in effect until such time as the group no longer self-insures these costs.

E. Any costs allowed pursuant to items A to C are subject to the following requirements:

(1) If the nursing facility is sold or otherwise ceases operations, the plan's reserves must be subject to an actuarially based settle-up after 36 months from the date of sale or the date on which operations ceased. The facility's medical assistance portion of the total excess plan reserves must be paid to the State within 30 days following the date on which excess plan reserves are determined.

(2) Any distribution of excess plan reserves made to or withdrawals made by the nursing facility or a related organization are applicable credits and must be used to reduce the nursing facility's workers' compensation costs in the reporting period in which a distribution or withdrawal is received.

(3) If reimbursement for the plan is sought under the federal Medicare program, and is audited pursuant to the Medicare Program, the nursing facility must provide a copy of Medicare's final audit report, including attachments and exhibits, to the Commissioner within 30 days of receipt by the nursing facility or any related organization. The Department shall implement the audit findings associated with the plan upon receipt of Medicare's final audit report. The Department's authority to implement the audit findings is independent of its authority to conduct a field audit.

F. The Department shall have authority to adopt emergency rules to implement this Section.

SECTION 6.084. **Group health, dental, or life insurance.** For the rate year beginning on July 1, 1998, a group of nursing facilities related by common ownership that self-insures group health,

dental or life insurance may allocate its directly identified costs of self-insuring its Minnesota nursing facility workers pursuant to Section 6.083, item D, subitem (7). The method of cost allocation is the same as in Section 6.083, item D, subitem (7). The costs associated with the administration of the group's self-insurance plan must remain classified in the nursing facility's administrative cost category. A written request of the nursing facility group's election to use this alternate method of allocation of self-insurance costs must be received by the Department no later than May 1, 1998, to take effect on July 1, 1998, or such costs will continue to be allocated under the existing cost allocation methods. Once a nursing facility group elects this method of cost allocation for its group health, dental, or life insurance self-insurance costs, it remains in effect until such time as the group no longer self-insures these costs.

SECTION 6.090 **Real estate taxes and special assessments.** Real estate taxes and special assessments for each nursing facility are to be reported in the real estate taxes and special assessments cost category. In addition, payments made in lieu of real estate taxes, unless such payments were made under a legally enforceable irrevocable written contract entered into prior to August 31, 1983, must be reported in this cost category.

SECTION 7.000 ESTABLISHMENT OF GEOGRAPHIC GROUPS

SECTION 7.010 **Classification process.** The Commissioner shall classify Minnesota nursing facilities according to their geographic location.

SECTION 7.020 **Group 1.** All nursing facilities in Beltrami, Big Stone, Cass, Chippewa, Clearwater, Cottonwood, Crow Wing, Hubbard, Jackson, Kandiyohi, Lac Qui Parle, Lake of the Woods, Lincoln, Lyon, Mahnomen, Meeker, Morrison, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift, Todd, Yellow Medicine, and Wadena counties must be placed in geographic group 1.

SECTION 7.030 **Group 2.** All nursing facilities in counties other than the counties listed in group 1 and group 3 must be placed in geographic group 2.

SECTION 7.040 **Group 3.** All nursing facilities in Aitkin, Anoka, Carlton, Carver, Cook, Dakota, Hennepin, Itasca, Koochiching, Lake, Ramsey, St. Louis, Scott, and Washington counties must be placed in geographic group 3.

SECTION 7.050 **Exceptions.**

A. Facilities in geographic Group 1 (lowest cost) may have their rates calculated based on the highest of the limits within Group 2 (middle cost) or Group 1. This exception is granted if it is to the facility's benefit and is done automatically at the time of ratesetting. In the event an exception is granted, efficiency payments are based on Group 1 limits.

B. Effective July 1, 2006, nursing facilities in Benton, Sherburne, and Stearns counties shall receive an operating rate increase to the median rate of Group 3 facilities.

SECTION 8.000 DETERMINATION AND ALLOCATION OF FRINGE BENEFITS AND PAYROLL TAXES, FOOD COSTS, AND DIETICIAN CONSULTING FEES

SECTION 8.010 **Fringe benefits and payroll taxes until July 1, 2001.** Fringe benefits and payroll taxes must be allocated to case mix, other care-related costs, and other operating costs according to items A to E.

A. For the rate years beginning on or after July 1, 1988, all of the nursing facility's fringe benefits and payroll taxes must be classified to the operating cost categories, based on direct identification. If direct identification cannot be used for all the nursing facility's fringe benefits and payroll taxes, the allocation method in items B to E must be used.

B. Fringe benefits and payroll taxes must be allocated to case mix operating costs in the same proportion to salaries reported under the nursing service category.

C. Fringe benefits and payroll taxes must be allocated to other care-related costs in the same proportion to salaries reported under the other care-related services category.

D. Fringe benefits and payroll taxes must be allocated to other operating costs in the same proportion to salaries reported under dietary, laundry and linen, housekeeping, plant operation and maintenance services, and the general and administrative categories.

E. For any nursing facility that cannot separately report each salary component of an operating cost category, the Department shall determine the fringe benefits and payroll taxes to be allocated under this subpart according to the following:(1) The Department shall sum the allowable salaries for all nursing facilities separately reporting allowable salaries in each cost category, by cost category and in total.

(2) The Department shall determine the ratio of the total allowable salaries in each cost category to the total allowable salaries in all cost categories, based on the totals in subitem (1).

(3) The nursing facility's total allowable fringe benefits and payroll taxes must be multiplied by each ratio determined in subitem (2) to determine the amount of payroll taxes and fringe benefits allocated to each cost category for the nursing facility under this item.

(4) If a nursing facility's salary for any nursing, dietary, laundry, housekeeping, plant operation and maintenance, other care-related services and general and administrative operating cost

categories, is zero and the services provided to the nursing facility in that operating cost category are not performed by a related organization, the nursing facility must reclassify one dollar to a salary cost line in the operating cost category. For rate years beginning on or after July 1, 1989, the Department shall include a nursing facility's reported public employee retirement act contribution for the reporting year as apportioned to the care-related operating cost categories multiplied by the appropriate composite index.

SECTION 8.020 **Determination of food costs until July 1, 1999.** The Department shall determine the costs of food to be included in other care-related costs according to items A and B.

A. For any nursing facility separately reporting food costs, food costs shall be the allowable food costs as reported under the dietary services cost category.

B. For any nursing facility that cannot separately report the cost of food under the dietary services cost category, the Department shall determine the average ratio of food costs to total dietary costs for all nursing facilities that separately reported food costs. The nursing facility's total allowable dietary costs must be multiplied by the average ratio to determine the food costs for the nursing facility.

SECTION 8.030 **Determination of dietician consulting fees until July 1, 1999.** The Department shall determine the dietician consulting fees to be included in other care-related costs according to items A and B.

A. For any nursing facility separately reporting dietician consulting fees, the dietician consulting fees shall be the allowable dietician consulting fees reported under the dietary services cost category.

B. For any nursing facility that has not separately reported dietician consulting fees, the Department shall determine the average cost per licensed bed of allowable dietician consulting fees for all nursing facilities that separately reported dietician consulting fees. The nursing facility's total number of licensed beds must be multiplied by the average cost per bed to determine the dietician consulting fees for the nursing facility.

SECTION 9.000 DETERMINATION OF THE ALLOWABLE HISTORICAL OPERATING COST PER DIEMS

SECTION 9.010 **Review and adjustment of costs.** The Department shall annually review and adjust the operating costs reported by the nursing facility during the reporting year preceding the rate year to determine the nursing facility's actual allowable historical operating costs.

SECTION 9.020 **Standardized resident days.** Each nursing facility's standardized resident days must be determined in accordance with items A to B.

A. The nursing facility's resident days for the reporting year in each resident class must be multiplied by the weight for that resident class.

B. The amounts determined in item A must be summed to determine the nursing facility's standardized resident days for the reporting year.

SECTION 9.030 **Allowable historical case mix operating cost standardized per diem.** Until July 1, 1999, the allowable historical case mix operating cost standardized per diem must be computed by the standardized resident days determined in Section 9.020.

SECTION 9.040 **Allowable historical other care-related operating cost per diem.** Until July 1, 1999, the allowable historical other care-related operating cost per diem must be computed by dividing the allowable historical other care-related operating costs by the number of resident days in the nursing facility's reporting year.

SECTION 9.050 **Allowable historical other operating cost per diem.** Until July 1, 1999, the allowable historical other operating cost per diem must be computed by dividing the allowable historical other operating costs by the number of resident days in the nursing facility's reporting year.

SECTION 10.000 DETERMINATION OF OPERATING COST ADJUSTMENT FACTORS AND LIMITS

SECTION 10.010 **Annual adjustment factors through June 30, 1999.** The annual adjustment factors will be determined according to items A and C.

A. The forecasted consumer price index for a nursing facility's allowable operating cost per diems shall be determined using Data Resources, Inc. forecast for the change in the nursing facility market basket between the mid point of the reporting year and the mid point of the rate year. For these purposes, the indices as forecasted by Data Resources, Inc. in the fourth quarter of the calendar year preceding the rate year will be utilized.

B. For rate years beginning on or after July 1, 1994, the Department will index the prior year's operating cost limits by the percentage change in the Data Resources, Inc., nursing home market basket between the midpoint of the current reporting year and the midpoint of the previous reporting year. The Department will use the indices as forecasted by Data Resources, Inc., in the fourth quarter of the calendar year preceding the rate year.

C. For the nine month rate period beginning October 1, 1992, the 21-month inflation factor for operating costs in item B shall be increased by an annualization of seven-tenths of one percent rounded to the nearest tenth percent.

SECTION 10.020 **Base year limits.** Until July 1, 1999, for each geographic group the base year operating costs limits must be determined according to items A and B. No redetermination of the base year operating costs limits shall be made due to audit adjustments or appeal settlement. For purposes of this section, a new base year is established for the rate year beginning July 1, 1992, and July 1, 1993.

A. The adjusted care-related limits must be indexed as in Sections 11.010 and 11.020. The adjusted other operating cost limits must be indexed as in Sections 11.030 and 11.040.

B. The Department shall disallow any portion of the general and administrative cost category, exclusive of fringe benefits and payroll taxes, that exceeds the percent of the allowable expenditures in all operating cost categories except fringe benefits, payroll taxes, and general and administrative as in subitems (1) to (3). For the purpose of computing the amount of disallowed general and administrative cost, the nursing facility's professional liability and property insurance must be excluded from the general and administrative cost category. For purposes of this item, the term property insurance means general liability coverage for personal injury incurred on the nursing facility property and coverage against loss or damage to the building, building contents, and the property of others on the premises of the nursing facility. Property insurance does not include any coverage for items such as automobiles, loss of earnings, and extra expenses.

(1) If the nursing facility's licensed beds exceed 195 licensed beds, the general and administrative cost category limitation shall be 13 percent.

(2) If the nursing facility's licensed beds are more than 150 licensed beds, but less than 196 licensed beds, the general and administrative cost category limitation shall be 14 percent; or

(3) If the nursing facility's licensed beds is less than 151 licensed beds, the general and administrative cost category limitation shall remain at 15 percent.

SECTION 10.030 **Indexed limits.** Until July 1, 1999, the total care related operating cost limit and the other operating cost limit must be determined under items A and B.

A. The annual adjustment factor for case mix and other care related operating costs for the current reporting year as determined in Section 10.010 must be divided by the corresponding annual adjustment factor for the previous reporting year.

B. The annual adjustment factor for other operating costs for the current reporting year as determined in Section 10.010 must be divided by the corresponding annual adjustment factor for the previous reporting year.

SECTION 11.000 DETERMINATION OF OPERATING COST PAYMENT RATE

SECTION 11.010 **Nonadjusted case mix and other care-related payment rate.** Until July 1, 1999, for each nursing facility, the nonadjusted case mix and other care-related payment rate for each resident class must be determined according to items A to D.

A. The nursing home's allowable historical case mix operating cost standardized per diem must be multiplied by the weight for each resident class.

B. The allowable historical other care-related operating cost per diem must be added to each weighted per diem established in item A.

C. If the amount determined in item B for each resident class is below the limit for that resident class and group item C, the nursing facility's nonadjusted case mix and other care-related payment rate must be the amount determined in item B for each resident class.

D. If the amount determined in item B for each resident class is at or above the limit for that resident class and group, the nursing facility's nonadjusted case mix and other care-related payment rate must be set at the limit.

SECTION 11.020 **Adjusted prospective case mix and other care-related payment rate.** Until July 1, 1999, for each nursing facility, the adjusted prospective case mix and other care-related payment rate for each resident class must be the nonadjusted case mix and other care-related payment rate multiplied by the case mix and other care-related adjustment factor.

SECTION 11.030 **Nonadjusted other operating cost payment rate.** Until July 1, 1999, the nonadjusted other operating cost payment rate must be determined according to items A and B.

A. If the allowable historical other operating cost per diem is below the limit for that group the nursing facility's nonadjusted other operating cost payment rate must be the allowable historical other operating cost per diem.

B. If the allowable historical other operating cost per diem is at or above the limit for that group the nursing facility's nonadjusted other operating cost payment rate must be set at that limit.

SECTION 11.040 **Adjusted prospective other operating cost payment rate until July 1, 1999.** The adjusted prospective other operating cost payment rate must be determined according to items A to C.

A. Except as provided in item B, if the nursing facility's nonadjusted other operating cost payment rate is below the limit for that group, the nursing facility's adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in

Section 11.030, item A, multiplied by the other operating cost adjustment factor plus, for the rate years before July 1, 1999, an efficiency incentive equal to the difference between the other operating cost limits in each geographic group and the nonadjusted other operating cost payment rate in Section 11.030, up to the maximum set forth in Section 11.047, item C.

B. For any short length of stay facility and any nursing facility licensed on June 1, 1983 by the Department to provide residential services for the physically handicapped that is under the limits, the nursing facility's adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in Section 11.030, item A, multiplied by the other operating cost adjustment factor determined in Section 10.010, item B, plus, for the rate years before July 1, 1999, an efficiency incentive equal to the difference between the other operating cost limits for hospital attached nursing facilities in each geographic group, and the nonadjusted other operating cost payment rate in Section 11.030, up to the maximum set forth in Section 11.047, item C.

C. If the nursing facility's nonadjusted other operating cost payment rate is at or above the limit for that group, the nursing facility's adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in Section 11.030, item B, multiplied by the other operating cost adjustment factor determined in Section 10.010, item B.

SECTION 11.042 **Efficiency incentive reductions for substandard care**. For rate years beginning on or after July 1, 1991, the efficiency incentive established in Section 11.047, item C, shall be reduced or eliminated for nursing facilities determined by the Commissioner of health to have uncorrected or repeated violations which create a risk to resident care, safety, or rights, except for uncorrected or repeated violations relating to a facility's physical plant. Upon being notified by the Commissioner of health of uncorrected or repeated violations, the Commissioner of human services shall require the nursing facility to use efficiency incentive payments to correct the violations. The Commissioner of human services shall require the nursing facility to forfeit efficiency incentive payments for failure to correct the violations. Any forfeiture shall be limited to the amount necessary to correct the violation.

SECTION 11.046 **Changes to nursing facility reimbursement beginning July 1, 1996.** The nursing facility reimbursement changes in items A through G are effective for one rate year beginning July 1, 1996. In addition, the Department must determine nursing facility payment rates for this rate year without regard to the changes in this section, the results of which will serve as the basis for allowed costs in the following rate years.

A. Except for purposes of the computation of the efficiency incentive in approved State plan amendment TN 99-10, Section 11.045, item D, which described the methodology for computing a nursing facility’s efficiency incentive for rates on or after July 1, 1995, the operating cost limits in Section 10.020, items A and B, and Section 16.138 do not apply.

B. Notwithstanding approved State plan amendment TN 99-10, Section 11.045, item E, subitem (2), which specified that the Nursing Home Market Basket forecasted index for allowable operating costs and per diems was based on the 12-month period between the midpoints of the two reporting years preceding the July 1, 1995 rate year, the operating cost limits in Section 10.020, items A and B are indexed for inflation as in Section 10.010, item B.

C. The high cost nursing facility limit in approved State plan amendment TN 99-10, Section 11.045, item B, which described how the high cost limit was determined for the July 1, 1995 rate year, does not apply.

D. The spend-up limit in approved State plan amendment TN 99-10, Section 11.045, item A, subitem (2), which described the allowable operating cost per diem limit, is modified as in subitems (1) to (3).

(1) For those nursing facilities in each grouping whose case mix A operating cost per diem is at or above the median plus 1.0 standard deviation of the array, the nursing facility's allowable operating cost per diem for each case mix category is limited to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor in approved State plan amendment TN 99-10, Section 11.045, item E, subitem (2), which specified that the Nursing home Market Basket forecasted index for allowable operating costs and per diems was based on the 12-month period between the midpoints of the two reporting years preceding the July 1, 1995 rate year, or the current reporting year's corresponding allowable operating cost per diem.

(2) For those nursing facilities in each grouping whose case mix A operating cost per diem is between .5 and 1.0 standard deviation above the median of the array, the nursing facility's allowable operating cost per diem for each case mix category is limited to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor in approved State plan amendment TN 99-10, Section 11.045, item E, subitem (2), described in subitem (1), above, increased by one percentage point, or the current reporting year's corresponding allowable operating cost per diem.

(3) For those nursing facilities in each grouping whose case mix A operating cost per diem is equal to or below .5 standard deviation above the median of the array, the nursing facility's allowable operating cost per diem is limited to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor in approved State plan amendment TN 99-10, Section 11.045, item E, subitem (2), described in subitem (1), above, increased by two percentage points, or the current reporting year's corresponding allowable operating cost per diem.

E. A nursing facility licensed by the State to provide services for the physically handicapped shall be exempt from the care related portion of the limit in approved State plan amendment TN 99-10, Section 11.045, item A, subitem (2), which described the allowable operating

cost per diem limit.

F. Any reductions to the combined operating cost per diem shall be divided proportionally between the care-related and other operating cost per diems.

G. Each nursing facility's payment rate, except those nursing facilities whose payment rates are established under Section 22.000, are increased by $.06 per resident per day.

SECTION 11.047 **Changes to nursing facility reimbursement beginning July 1, 1997.** The nursing facility reimbursement changes in items A through L shall apply, in the sequence specified, beginning July 1, 1997.

A. For rate years beginning on July 1, 1997 or July 1, 1998, the nursing facility's allowable operating per diem for each case mix category for each rate year shall be limited as described below.

For rate years beginning on July 1, 1997 or July 1, 1998, nursing facilities shall be divided into two groups, freestanding and nonfreestanding, within each geographic group. A nonfreestanding nursing facility is a nursing facility whose other operating cost per diem is subject to the limits contained in Sections 20.025, 20.030, or 20.035. All other nursing facilities shall be considered freestanding nursing facilities. All nursing facilities in each grouping will be arrayed by their allowable case mix A operating cost per diem. In calculating a nursing facility's operating cost per diem for this purpose, the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in Section 8.020, item B, shall be excluded.

For those nursing facilities in each grouping whose case mix A operating cost per diem:

(a) is at or below the median of the array, the nursing facility's allowable operating cost per diem for each case mix category shall be limited to the lesser of the prior reporting year's allowable operating cost per diem by computing nursing facility payment rates based on the payment rate methodology in effect on March 1, 1996 (see approved State plan amendment TN 99-10, Section 11.045), plus the inflation factor as established in item D, subitem (2), increased by two percentage points, or the current reporting year's corresponding allowable operating cost per diem; or

(b) is above the median of the array, the nursing facility's allowable operating cost per diem for each case mix category shall be limited to the lesser of the prior reporting year's allowable operating cost per diems by computing nursing facility payment rates based on the payment rate methodology in effect on March 1, 1996 (see approved State plan amendment TN 99-10, Section 11.045) plus the inflation factor as established in item D, subitem (2), increased by one percentage point, or the current reporting year's corresponding allowable operating cost per diem.

(c) For the purposes of this item, if a nursing facility reports on its cost report a

reduction in cost due to a refund or credit for a rate year beginning on or after July 1, 1998, the Department will increase that facility's spend-up limit for the rate year following the current rate year by the amount of the cost reduction divided by its resident days for the reporting year preceding the rate year in which the adjustment is to be made.

B. For rate years beginning on July 1, 1997 or July 1, 1998, the allowable operating cost per diems for high cost nursing facilities shall be limited as described. After application of the limits in item A to each nursing facility's operating cost per diems, nursing facilities shall be divided into two groups, freestanding or nonfreestanding, and arrayed within these groupings according to allowable case mix A operating cost per diems.

In calculating a nursing facility's operating cost per diem for this purpose, the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in Section 8.020, item B, shall be excluded.

For those nursing facilities in each grouping whose case mix A operating cost per diems exceeds 1.0 standard deviation above the median, the allowable operating cost per diems will be reduced by three percent. For those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 0.5 standard deviation above the median but is less than or equal to 1.0 standard above the median, the allowable operating cost per diems will be reduced by two percent. However, in no case shall a nursing facility's operating cost per diem be reduced below its grouping's limit established at 0.5 standard deviations above the median.

C. For rate years beginning on July 1, 1997 or July 1, 1998, a nursing facility's efficiency incentive shall be determined by first computing the allowable difference, which is the lesser of $4.50 or the amount by which the facility's other operating cost limit exceeds its nonadjusted other operating cost per diem for that rate year. Then, the efficiency incentive is computed by:

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

(2) Multiplying 0.20 by the ratio resulting from subitem (1);

(3) Adding 0.50 to the result from subitem (2); and

(4) Multiplying the result from subitem (3) times the allowable difference.

The nursing facility's efficiency incentive payment shall be the lesser of $2.25 or the product obtained through calculations of subitems (1) through (4).

D. For rate years beginning on July 1, 1997 or July 1, 1998, the forecasted price index for a nursing facility's allowable operating cost per diems shall be determined under subitems (1) and (2)

using the change in the Consumer Price Index - All Items (United States city average) (CPI-U) as forecasted by Data Resources, Inc. The indices as forecasted in the fourth quarter of the calendar year preceding the rate year shall be used.

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

(2) For rate years beginning on July 1, 1997 or July 1, 1998, the forecasted index for operating cost limits referred to in Section 10.010, item B, shall be based on the CPI-U for the 12-month period between the midpoints of the two reporting years preceding the rate year.

E. After applying these provisions for the respective rate years, allowable operating cost per diems shall be indexed by the inflation factor provided for in item D, subitem (1), and the nursing facility's efficiency incentive as calculated in item C shall be added.

F. For the rate years beginning on July 1, 1997, July 1, 1998, and July 1, 1999, a nursing facility licensed for 40 beds effective May 1, 1992, with a subsequent increase of 20 Medicare/Medicaid certified beds, effective January 26, 1993, in accordance with an increase in licensure is exempt from Section 11.046, items A to D, and Section 11.047, items A to D, respectively.

G. For the rate year beginning July 1, 1997, for a nursing facility that submitted a proposal after January 13, 1994, involving replacement of 102 licensed and certified beds and relocation of the existing first facility to a new location, that was approved under the State's moratorium exception process, the operating cost payment rates for the new location shall be determined pursuant to Section 12.000. The relocation approved under the State's moratorium exception process, and the rate determination allowed under this item must meet the cost neutrality requirements of the State's moratorium exception process. Items A and B do not apply until the second rate year after the settle-up cost report is filed. Notwithstanding Section 17.000, payments in lieu of real estate taxes and special assessments payable by the new location, a non profit corporation, as part of tax increment financing, shall be included in the payment rates determined under this section for all subsequent rate years.

H. For the rate year beginning July 1, 1997, for a nursing facility licensed for 94 beds on September 30, 1996 that applied in October 1993 for approval of a total replacement under the State's moratorium exception process and completed the approved replacement in June 1995, the Department shall compute the payment rate with other operating cost spend-up limit under item A. This amount is increased by $3.98, and, after computing the facility's payment rate according to this Section, the Department shall make a one-year positive rate adjustment of $3.19 for operating costs related to the newly constructed total replacement, without application of items A and B. The

facility's per diem, before the $3.19 adjustment, shall be used as the prior reporting year's allowable operating cost per diem for payment rate calculation for the rate year beginning July 1, 1998. A facility described in this item is exempt from item B for the rate years beginning July 1, 1997 and July 1, 1998.

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

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

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

L. A 49 bed nursing facility located in Norman County destroyed by the spring floods of 1997 is eligible for total replacement. The nursing facility shall have its operating cost payment rates established using the provisions in Section 12.000, except that the limits in items A and B of this section shall not apply until after the second rate year after the settle-up cost report is filed. The property-related payment rate is determined pursuant to Section 16.000, taking into account any federal or state flood-related loans or grants.

M. (1) After computing the payment rate of the 302 bed nursing facility in Section 11.046, item H, the Department must make a one-year rate adjustment of $8.62 to the facility's contract payment rate for the rate effect of operating cost changes associated with the facility's 1994 downsizing project.

(2) The Department must also add 35 cents to the facility's base property related payment rate for the rate effect of reducing its licensed capacity to 290 beds from 302 beds and must add 83 cents to the facility's real estate tax and special assessment payment rate for payments in lieu of real estate taxes. The adjustments in this subitem must remain in effect for the duration of the facility's contract.

SECTION 11.048 **Changes to nursing facility reimbursement beginning July 1, 1998.**

A. For the purpose of applying the limit in Section 11.047, item A, a nursing facility in Hennepin county licensed for 181 beds on September 30, 1996, has the prior year's allowable care-

related per diem increased by $1.455 and the prior year's other operating cost per diem increased by $0.439 before adding the inflation in Section 11.047, item D, subitem (2), for the rate year beginning July 1, 1998.

B. For the purpose of applying the limit in Section 11.047, item A, a nursing facility in Hennepin county licensed for 161 beds on September 30, 1996, has the prior year's allowable care-related per diem increased by $1.154 and the prior year's other operating cost per diem increased by $0.256 before adding the inflation in Section 11.047, item D, subitem (2), for the rate year beginning July 1, 1998.

C. For the purpose of applying the limit in Section 11.047, item A, a nursing facility in Ramsey county licensed for 176 beds on September 30, 1996, has the prior year's allowable care-related per diem increased by $.083 and the prior year's other operating cost per diem increased by $0.272 before adding the inflation in Section 11.047, item D, subitem (2), for the rate year beginning July 1, 1998.

D. For the purpose of applying the limit in Section 11.047, item A, a nursing facility in Brown county licensed for 86 beds on September 30, 1996, has the prior year's allowable care-related per diem increased by $0.850 and the prior year's other operating cost per diem increased by $0.275 before adding the inflation in Section 11.047, item D, subitem (2), for the rate year beginning July 1, 1998.

E. For the rate year beginning July 1, 1998, the Department will compute the payment rate for a nursing facility, which was licensed for 110 beds on May 1, 1997, was granted approval in January 1994 for a replacement and remodeling project under the moratorium exception process and completed the approval replacement and remodeling project on May 14, 1997, by increasing the other operating cost spend-up limit under item A by $1.64. After computing the facility's payment rate for the rate year beginning July 1, 1998, according to this section, the Department will make a one-year positive rate adjustment of $.48 for increased real estate taxes resulting from completion of the moratorium exception project, without application of items A and B.

F. For the rate year beginning July 1, 1998, the Department will compute the payment rate for a nursing facility exempted from the care-related limits under Section 20.030, with a minimum of three-quarters of its beds licensed to provide residential services for the physically handicapped, with the care-related spend-up limit of Section 11.047, item A, increased by $13.21 for the rate year beginning July 1, 1998, without application of Section 11.047, item B. For rate years beginning on or after July 1, 999, the Department will exclude that amount in calculating the facility's operating cost per diem for purposes of applying Section 11.047, item B.

G. For the rate year beginning July 1, 1998, a nursing facility in Canby, Minnesota, licensed for 75 beds will be reimbursed without the limitation imposed in Section 11.047, item A, and for rate

years beginning on or after July 1, 1999, its base costs will be calculated on the basis of its September 30, 1997 cost report.

H. Effective July 1, 1998, the nursing facility reimbursement changes in subitems (1) and (2) will apply in the sequence specified in this section.

(1) For rate years beginning on July 1, 1998, the operating cost limits established by Section 10.020, item B, subitems (1) through (3); Section 16.138; and any previously effective corresponding limits in state law or rule do not apply, except that these cost limits will still be calculated for purposes of determining efficiency incentive per diems in Section 11.047, item D. For rate years beginning on July 1, 1998, the total operating cost payment rates for a nursing facility are the greater of the total operating cost payment rates determined under this section or the total operating cost payment rates in effect on June 30, 1998, subject to rate adjustments due to field audit or rate appeal resolution.

(2) For rate years beginning on July 1, 1998, the operating cost per diem in Section 11.047, item A, subitem (1), units (a) and (b), is the sum of the care-related and other operating per diems for a given case mix class. Any reductions to the combined operating per diem are divided proportionally between the care-related and other operating cost per diems.

I. For rate years beginning on July 1, 1998, the Department will modify the determination of the spend-up limits in Section 11.047, item A, by indexing each group's previous year's median value by the factor in Section 11.0147, item D, subitem (2), plus one percentage point.

J. For rate years beginning on July 1, 1998, the Department will modify the determination of the high cost limits in Section 11.047, item B, by indexing each groups previous year's high cost per diem limits at .5 and one standard deviations above the median by the factor in Section 11.047, item D, subitem (2), plus one percentage point.

SECTION 11.049 **Changes to nursing facility reimbursement beginning July 1, 1999.**

A. The base operating rate is the rate for the rate year beginning July 1, 1998.

B. For the rate year beginning July 1, 1999, the Department will make an adjustment to the total operating payment rate for a nursing facility paid by the prospective rate-setting methodology described in Sections 1.000 to 21.000 or by the contractual rate-setting methodology described in Section 22.000 that submits a plan, approved by the Department, in accordance with subitem (2). Total operating costs will be separated into compensation-related costs and all other costs. Compensation-related costs include salaries, payroll taxes, and fringe benefits for all employees except management fees, the administrator, and central office staff.

(1) For the rate year beginning July 1, 1999, the payment rate is increased by 4.843 percent of compensation-related costs and 3.446 percent of all other operating costs. A nursing facility's final 1998 Medicare cost report will be used to calculate the adjustment.

(2) To receive the total operating payment rate adjustment, a nursing facility must apply to the Department. The application must contain a plan by which the nursing facility will distribute the compensation-related portion of the payment rate adjustment to employees of the nursing facility. For a nursing facility 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) The Department will review the plan to ensure that the payment rate adjustment per diem is used as provided in subitem (1).

(b) To be eligible, a nursing facility must submit its plan for the compensation distribution by December 31 each year. A nursing facility may amend its plan for the second rate year by submitting a revised plan by December 31, 2000. If a nursing facility's plan for compensation distribution is effective for its employees after July 1 of the year that the funds are available, the payment rate adjustment per diem shall be effective the same date as its plan.

(3) The payment rate adjustment for each nursing facility will be determined under clauses (a) or (b).

(a) For a nursing facility that reports salaries for registered nurses, licensed practical nurses, aides, orderlies, and attendants separately, the Department will determine the payment rate adjustment using the categories listed above multiplied by the rate increases in subitem (1), and then dividing the resulting amount by the nursing facility's actual resident days. In determining the amount of a payment rate adjustment for a nursing facility paid under Section 22.000, the Department must determine the proportions of the nursing facility's rates that are compensation-related costs and all other operating costs based on its most recent cost report; or

(b) For a nursing facility that does not report salaries for registered nurses, licensed practical nurses, aides, orderlies, and attendants separately, the payment rate adjustment will be computed using the nursing facility's total operating costs, separated into the categories listed above in proportion to the weighted average of all nursing facilities determined under subitem (3), clause (a), multiplied by the rate increases in subitem (1), and then dividing the resulting amount by the nursing facility's actual resident days.

C. The salary adjustment per diem in Section 11.070 became part of the operating payment rate in effect on June 30, 2001.

D. For the rate year beginning July 1, 1999, the following nursing facilities are allowed a rate increase equal to 67 percent of the rate increase that would be allowed if Section 11.047, item A was not applied:

(1) A nursing facility in Carver county licensed for 33 beds and four boarding care beds;

(2) A nursing facility in Faribault county licensed for 159 beds on September 30, 1998; and

(3) A nursing facility in Houston county licensed for 68 beds on September 30, 1998.

These increases are included in each facility's total payment rates for the purpose of determining future rates.

E. For the rate year beginning July 1, 1999, the following nursing facilities will be allowed a rate increase equal to 67 percent of the rate increase that would be allowed if Section 11.047, items A and B were not applied:

(1) A nursing facility in Chisago county licensed for 135 beds on September 30, 1998; and

(2) A nursing facility in Murray county licensed for 62 beds on September 30, 1998.

These increases are included in each facility's total payment rates for the purpose of determining future rates.

F. For the rate year beginning July 1, 1999, a nursing facility in Hennepin county licensed for 134 beds on September 30, 1998, will:

(1) Have the prior year's allowable care-related per diem increased by $3.93 and the prior year's other operating cost per diem increased by $1.69 before adding the inflation in Section 11.047, item D, subitem (2); and

(2) Be allowed a rate increase equal to 67 percent of the rate increase that would be allowed if Section 11.047, items A and B were not applied.

These increases are included in the facility's total payment rate for the purpose of determining future rates.

SECTION 11.050 **Changes to nursing facility reimbursement beginning July 1, 2000.**

A. The base operating rate is the rate for the rate year beginning July 1, 1998.

B. For the rate year beginning July 1, 2000, the Department will make an adjustment to the total operating payment rate for a nursing facility paid by the prospective rate-setting methodology described in Sections 1.000 to 21.000 or by the contractual rate-setting methodology described in Section 22.000 that submits a plan, approved by the Department, in accordance with subitem (2). The operating payment rate increases are applied to each nursing facility's June 30, 2000, operating payment rate.

Total operating costs will be separated into compensation-related costs and all other costs. Compensation-related costs include salaries, payroll taxes, and fringe benefits for all employees except management fees, the administrator, and central office staff.

(1) For the rate year beginning July 1, 2000, the payment rate is increased by:

(a) 3.632 percent of compensation-related costs;

(b) an additional increase for each case mix payment rate that must be used to increase the per-hour pay rate of all employees except management fees, the administrator, and central office staff by an equal dollar amount and to pay associated costs for FICA, the Medicare tax, workers' compensation premiums, and federal and state unemployment insurance, to be calculated according to the following:

1. the Department calculates the arithmetic mean of the eleven June 30, 2000, operating rates for each nursing facility;

2. the Department constructs an array of nursing facilities from highest to lowest, according to the arithmetic mean calculated in clause 1. A numerical rank is assigned to each facility in the array. The facility with the highest mean is assigned a numerical rank of one. The facility with the lowest mean is assigned a numerical rank equal to the total number of nursing facilities in the array. All other facilities are assigned a numerical rank in accordance with their position in the array;

3. the amount of the additional rate increase is $1.00 plus an amount equal to $3.13 multiplied by the ratio of the facility's numeric rank divided by the number of facilities in the array; and

(c) 2.585 percent of all other operating costs. A nursing facility's final 1999 Medicare cost report will be used to calculate the adjustment.

Money received by a nursing facility as a result of the increase provided by (b), above, must be used only for wage increases implemented on or after July 1, 2000, and must not be used for wage

increases implemented before then.

(2) To receive the total operating payment rate adjustment, a nursing facility must apply to the Department. The application must contain a plan by which the nursing facility will distribute the compensation-related portion of the payment rate adjustment to employees of the nursing facility. For a nursing facility 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, but only if the agreement is finalized after May 16, 2000.

(a) The Department will review the plan to ensure that the payment rate adjustment per diem is used as provided in subitem (1).

(b) To be eligible, a nursing facility must submit its plan for the compensation distribution by December 31 each year. A nursing facility may amend its plan for the second rate year by submitting a revised plan by December 31, 2000. If a nursing facility's plan for compensation distribution is effective for its employees after July 1 of the year that the funds are available, the payment rate adjustment per diem shall be effective the same date as its plan.

(3) The payment rate adjustment for each nursing facility will be determined under clauses (a) or (b).

(a) For a nursing facility that reports salaries for registered nurses, licensed practical nurses, aides, orderlies, and attendants separately, the Department will determine the payment rate adjustment using the categories listed above multiplied by the rate increases in subitem (1), and then dividing the resulting amount by the nursing facility's actual resident days. In determining the amount of a payment rate adjustment for a nursing facility paid under Section 22.000, the Department must determine the proportions of the nursing facility's rates that are compensation-related costs and all other operating costs based on its most recent cost report; or

(b) For a nursing facility that does not report salaries for registered nurses, licensed practical nurses, aides, orderlies, and attendants separately, the payment rate adjustment will be computed using the nursing facility's total operating costs, separated into the categories listed above in proportion to the weighted average of all nursing facilities determined under subitem (3), clause (a), multiplied by the rate increases in subitem (1), and then dividing the resulting amount by the nursing facility's actual resident days.

C. The salary adjustment per diem in Section 11.070 became part of the operating payment rate in effect on June 30, 2001.

D. For rate years beginning on or after July 1, 2000, a nursing facility in Goodhue county

that was licensed for 104 beds on February 1, 2000, shall have its employee pension benefit costs reported on its Rule 50 cost report treated as PERA contributions for the purpose of computing its payment rates.

E. Following the determination under item B, a facility in Roseau county licensed for 49 beds, has its operating cost per diem increased by the following amounts:

(1) case mix class A, $1.97;

(2) case mix class B, $2.11;

(3) case mix class C, $2.26;

(4) case mix class D, $2.39;

(5 case mix class E, $2.54;

(6) case mix class F, $2.55;

(7) case mix class G, $2.66;

(8) case mix class H, $2.90;

(9) case mix class I, $2.97;

(10) case mix class J, $3.10; and

(11) case mix class K, $3.36.

These increases are included in the facility's total payment rates for the purpose of determining future rates.

SECTION 11.051 **Changes to nursing facility reimbursement beginning July 1, 2001.**

A. For the rate year beginning July 1, 2001, the Department will provide an adjustment equal to 3.0 percent of the total operating payment rate. The operating payment rates in effect on June 30, 2001 include the adjustment in Section 11.070.

B. For rate years beginning on or after July 1, 2001 and for admissions occurring on or after July 1, 2001, the total payment rate for the first 90 paid days after admission is:

(1) for the first 30 paid days, 120 percent of the facility’s medical

assistance rate for each case mix class; and

(2) for the next 60 paid days after the first 30 paid days, 110 percent of the facility's medical assistance rate for each case mix class.

C. For rate years beginning on or after July 1, 2001 and for admissions occurring on or after July 1, 2001, beginning with the 91st paid day after admission, the payment rate is the rate otherwise determined under this Attachment.

D. Payments under item B apply to admissions occurring on or after July 1, 2001, and before July 1, 2003, and to resident days occurring before July 30, 2003.

E. For the rate year beginning July 1, 2001, the Department will adjust the operating payment rates for low-rate facilities. For each case mix level, if the amount computed under item A is less than the amount of the operating payment rate target level for July 1, 2001, below, the Department will make available the lesser of the amount of the operating payment rate target level for July 1, 2001, or an increase of ten percent over the rate in effect on June 30, 2001, as an adjustment to the operating payment rate. For the purposes of this item, facilities are considered metro if they are located in Anoka, Carver, Dakota, Hennepin, Olmsted, Ramsey, Scott, or Washington counties; or in the cities of Moorhead or Brekenridge; or in St. Louis county, north of Toivola and south of Cook; or in Itasca county, east of a north south line two miles west of Grand Rapids.

Operating Payment Rate Target Level for July 1, 2001

Case Mix Classification	Metro	Nonmetro
A	$76.00	$68.13
B	$83.40	$74.46
C	$91.67	$81.63
D	$99.51	$88.04
E	$107.46	$94.87
F	$107.96	$95.29
G	$114.67	$100.98
H	$126.99	$111.31
I	$131.34	$115.06
J	$138.34	$120.85
K	$152.26	$133.10

E. For the rate year beginning July 1, 2001, two-thirds of the money resulting from the rate adjustment under item A, and one-half of the money resulting from the rate adjustment under items B through D, must be used to increase the wages and benefits and pay associated costs of all

employees except management fees, the administrator, and central office staff.

(1) Money received by a facility resulting from the rate adjustments under items A through D must be used only for wage and benefit increases implemented on or after July 1, 2001.

(2) A facility may apply for the portions of the rate adjustments under this item. The application must be made to the Department and contain a plan by which the facility will distribute the funds to its employees. For a facility 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, if the agreement is finalized after June 30, 2001.

(a) The Department will review the plan to ensure that the rate adjustments are used as required in this item.

(b) To be eligible, a facility must submit its plan for the wage and benefit distribution by December 31, 2001. If a facility's plan for wage and benefit distribution is effective for its employees after July 1, 2001, the portion of the rate adjustments are effective the same date as its plan.

(3) A hospital-attached facility may include costs in its distribution plan for wages and benefits and associated costs of employees in that organization's shared services departments, provided that the facility and the hospital share common ownership and adjustments for hospital services using the diagnostic-related grouping payment rates per admission under Medicare are less than three percent during the 12 months before July 1, 2001. If a hospital-attached facility meets these qualifications, the difference between the rate adjustments approved for nursing facility services and the rate increase approved for hospital services may be permitted as a distribution in the hospital-attached facility's plan regardless of whether the use of the funds is shown as being attributable to employee hours worked in the facility or employee hours worked in the hospital.

F. Notwithstanding Sections 1.020 and 18.020, upon the request of a facility, the Department may authorize the facility to raise per diem rates for private-pay residents on July 1 by the amount anticipated to be required upon implementation of the rate adjustments allowable under items A through D. Until the rate is finalized, the Department will require any amounts collected, which must be used as provided in this item, to be placed in an escrow account established for this purpose with a financial institution that provides deposit insurance. The Department shall conduct audits as necessary to ensure that:

(1) the amounts collected are retained in escrow until rates are increased to reflect the wage-related adjustment; and

(2) any amounts collected from private-pay residents in excess of the final rate are repaid to the private-pay residents with interest.

G. For rate years beginning on or after July 1, 2001, in calculating a facility's operating cost per diem for the purposes of constructing an array, determining a median, or otherwise performing a statistical measure of facility payment rates to be used to determine future rate increases, the Department will exclude adjustments for raw food costs under Section 8.020, item B, that are related to providing special diets based on religious beliefs.

SECTION 11.052 **Changes to nursing facility reimbursement beginning July 1, 2002.**

A. For the rate year beginning July 1, 2002, the Department will provide an adjustment equal to 3.0 percent of the total operating payment rate. The operating payment rates in effect on June 30, 2001 include the adjustment in Section 11.070.

B. For the rate year beginning July 1, 2002, the Department will adjust the operating payment rates for low-rate facilities. For each case mix level, if the amount computed under item A is less than the amount of the operating payment rate target level for July 1, 2002, below, the Department will make available the lesser of the operating payment rate target level for July 1, 2002, or an increase of ten percent over the rate in effect on June 30, 2002, as an adjustment to the operating payment rate. For the purposes of this item, facilities are considered metro if they meet the requirements in Section 11.051, item D.

Operating Payment Rate Target Level for July 1, 2002

Case Mix Classification	Metro	Nonmetro
A	$78.28	$70.51
B	$85.91	$77.16
C	$94.42	$84.62
D	$102.50	$91.42
E	$110.68	$98.40
F	$111.20	$98.84
G	$118.11	$104.77
H	$130.80	$115.64
I	$135.38	$119.50
J	$142.49	$125.38
K	$156.85	$137.77

C. For the rate year beginning July 1, 2002, two-thirds of the money resulting from the

rate adjustment under item A, and one-half of the money resulting from the rate adjustment under Section 11.051, items B and C and item B of this Section, must be used to increase the wages and benefits and pay associated costs of all employees except management fees, the administrator, and central office staff.

(1) Money received by a facility resulting from the rate adjustments under item A, Section 11.051, items B and C and item B of this Section must be used only for wage and benefit increases implemented on or after July 1, 2002.

(2) A facility may apply for the portions of the rate adjustments under this item. The application must be made to the Department and contain a plan by which the facility will distribute the funds to its employees. For a facility 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, if the agreement is finalized after the date of enactment of all increases for the rate year.

(a) The Department will review the plan to ensure that the rate adjustments are used as required in this item.

(b) To be eligible, a facility must submit its plan for the wage and benefit distribution by December 31, 2002. If a facility's plan for wage and benefit distribution is effective for its employees after July 1, 2002, the portion of the rate adjustments are effective the same date as its plan.

(3) A hospital-attached facility may include costs in its distribution plan for wages and benefits and associated costs of employees in that organization's shared services departments, provided that the facility and the hospital share common ownership and adjustments for hospital services using the diagnostic-related grouping payment rates per admission under Medicare are less than three percent during the 12 months before July 1, 2002. If a hospital-attached facility meets these qualifications, the difference between the rate adjustments approved for nursing facility services and the rate increase approved for hospital services may be permitted as a distribution in the hospital-attached facility's plan regardless of whether the use of the funds is shown as being attributable to employee hours worked in the facility or employee hours worked in the hospital.

D. Notwithstanding Sections 1.020 and 18.020, upon the request of a facility, the Department may authorize the facility to raise per diem rates for private-pay residents on July 1 by the amount anticipated to be required upon implementation of the rate adjustments allowable under item A, Section 11.051, items B and C, and item B of this Section. Until the rate is finalized, the Department will require any amounts collected, which must be used as provided in this item, to be placed in an escrow account established for this purpose with a financial institution that provides deposit insurance. The Department shall conduct audits as necessary to ensure that:

(1) the amounts collected are retained in escrow until rates are increased to reflect the wage-related adjustment; and

(2) any amounts collected from private-pay residents in excess of the final rate are repaid to the private-pay residents with interest.

E. Each facility paid pursuant to Sections 1.000 through 22.000 receives an increase in each case mix payment rate of $1.25, which is added following the determination of the payment rate for the facility. This increase is not subject to any annual percentage increase.

SECTION 11.053 **Changes to nursing facility reimbursement beginning June 1, 2003.**

Each facility paid pursuant to Sections 1.000 through 21.000 receives an increase in each case mix payment rate of $5.56, which is added following the determination of the payment rate for the facility. This increase is not subject to any annual percentage increase. For facilities with board and care beds, the increase is equal to $5.56 multiplied by the ratio of the number of nursing home beds to the number of total beds.

SECTION 11.054 **Changes to nursing facility reimbursement beginning July 1, 2003.**

A. For rate years beginning on or after July 1, 2003 and for admissions occurring on or after July 1, 2003, the total payment rate is:

(1) for the first 30 calendar days after admission, 120 percent of the facility's medical assistance rate for each RUG class; and

(2) beginning with the 31st calendar day after admission, the rate otherwise determined under Sections 1.000 through 21.000.

B. For rate years beginning on or after July 1, 2003, facilities' July 1 operating payment rate is equal to their operating payment rate in effect on the prior June 30.

SECTION 11.055 **Changes to nursing facility reimbursement beginning January 1, 2004.** Effective January 1, 2004, the rates under Section 11.054, item A, subitem (1) are not allowed if a resident has resided during the previous 30 calendar days in:

(1) the same facility;

(2) a facility owned or operated by a related party; or

(3) a facility or part of a facility that closed or, effective August 1, 2004,

was in the process of closing.

SECTION 11.056 **Changes to nursing facility reimbursement beginning July 1, 2005**.

A. Medical Assistance provides for an additional annual payment for: 1) State Fiscal Year 2006 (July 1, 2005 through June 30, 2006), which includes a Department payment made for that state fiscal year and distributed by a sponsoring institution prior to October 1, 2006; and 2) State Fiscal Year 2007 (July 1, 2006 through June 30, 2007), which includes a Department payment made for that state fiscal year and distributed by a sponsoring institution prior to October 1, 2007, to Medical Assistance-enrolled teaching nursing facilities. The Medical Assistance payment is increased according to the sum of items A through C:

(1) (Total amount available for this purpose in the Minnesota Medical Education and Research Trust Fund, minus $4,850,000, divided by the state matching rate), multiplied by .9, multiplied by .67, multiplied by [(the number of full-time equivalent trainees at the facility multiplied by the average cost per trainee for all sites) divided by (the total training costs across all sites)], for each type of graduate trainee at the clinical site.

(2) (Total amount available for this purpose in the Minnesota Medical Education and Research Trust Fund, minus $4,850,000, divided by the state matching rate), multiplied by .9, multiplied by .33, multiplied by the ratio of the facility's public program revenue to the public program revenue for all teaching sites.

(3) (A portion of the total amount available for this purpose in the Minnesota Medical Education and Research Trust Fund minus $4,850,000), divided by the state matching rate, multiplied by .10, multiplied by the provider's sponsoring institution's ratio of the amounts in subitems (1) and (2) to the total dollars available under subitems (1) and (2), in the amount the sponsoring institution determines is necessary to offset clinical costs at the facility.

In accordance with Code of Federal Regulations, title 42, section 447.253(b)(2), this payment will not exceed the Medicare upper limit payment and charge limits as specified in Code of Federal Regulations, title 4, section 447.272.

B. Pursuant to subitems (1) through (3), the operating payment rate for each facility paid pursuant to Sections 1.000 through 21.000 is increased by 20 percent multiplied by the ratio of the number of new single-bed rooms created, divided by the number of active beds on July 1, 2005, for each bed closure resulting in the creation of a single-bed room after July 1, 2005.

(1) The Department may implement rate adjustments for up to 3,000 new single-bed rooms each fiscal year.

(2) For eligible bed closures for which the Department receives a notice from a facility during a calendar quarter that a bed has been delicensed and a new single-bed room has been established, the rate adjustment is effective on the first day of the second month following that calendar quarter. For single-bed rooms established after August 1, 2017, the rate adjustment is effective on the first day of the month of January or July, whichever occurs first, following the day on which a bed has been delicensed and a new single-bed room has been established.

(3) A facility is prohibited from discharging residents for purposes of establishing single-bed rooms. A facility must submit documentation to the Department certifying the occupancy status of beds closed to create single-bed rooms.

SECTION 11.057 **Changes to nursing facility reimbursement beginning October 1, 2005.**

A. For the rate period beginning October 1, 2005, each facility paid pursuant to Sections 1.000 through 21.000 receives an adjustment equal to 2.2553 percent of the total operating payment rate. The adjustment is distributed according to items B through D, below.

B. Except as provided in item C, 75% of the money resulting from the rate adjustment must be used to increase employee wages, benefits and associated costs and must be implemented on or after the effective date of the rate increase. “Employee” does not include management fees, the administrator, and central office staff.

C. A facility that incurred costs for employee wages, benefits and associated cost increases first provided after July 1, 2003 may count those costs toward the amount required to be spent on the items in item B. These costs must be reported to the Department.

D. A facility may apply for the 75% portion of the rate adjustment for employee wages, benefits and associated costs. The application must be made to the Department and contain a plan by which the facility will distribute the funds according to items B through C. For a facility 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, if the agreement is finalized after that date of enactment of all increases for the rate period and signed by both parties prior to submission to the Department.

(1) The Department will review the plan to ensure that the rate adjustments are used as required in items B through C.

(2) To be eligible, a facility must submit its distribution plan by March 31, 2006. 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 day as the facility’s plan.

(3) The Department must approve or disapprove distribution plans on or before June 30, 2006.

SECTION 11.058 **Changes to nursing facility reimbursement beginning October 1, 2006.**

Effective October 1, 2006, a facility that elects to have its rates determined under sections 1.000 through 21.000 of Attachment 4.19-D will continue to be paid the rate in effect for rate year October 1, 2005 through September 30, 2006.

SECTION 11.060 **Total operating cost payment rate.** Through June 30, 1999, the nursing facility's total operating cost payment rate must be the sum of the adjusted prospective case mix and other care-related payment rate determined in Section 11.020 and the adjusted other operating cost payment rate determined in Section 11.040.

SECTION 11.070 **Salary adjustment per diem.** Effective July 1, 1998, the Department shall make available the appropriate salary adjustment per diem calculated in item A through D to the total operating cost payment rate of each nursing facility subject to payment under this attachment, including Section 22.000. The salary adjustment per diem for each nursing facility must be determined as follows:

A. For each nursing facility that reports salaries for registered nurses, licensed practical nurses, and aides, orderlies and attendants separately, the Department shall determine the salary adjustment per diem by multiplying the total salaries, payroll taxes, and fringe benefits allowed in each operating cost category, except management fees and administrator and central office salaries and the related payroll taxes and fringe benefits, by 3.0 percent and then dividing the resulting amount by the nursing facility's actual resident days.

B. For each nursing facility that does not report salaries for registered nurses, licensed practical nurses, aides, orderlies, and attendants separately, the salary adjustment per diem is the weighted average salary adjustment per diem increase determined under item A.

C. A nursing facility may apply for the salary adjustment per diem calculated under items A and B. The application must be made to the Department and contain a plan by which the facility will distribute the salary adjustment to employees of the facility. In order to apply for a salary adjustment, a facility reimbursed pursuant to Section 22.000 must report the information required by items A or B in the application, in the manner specified by the Department. For 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, after July 1, 1998, may constitute the plan for the salary distribution. The Department will review the plan to ensure that the salary adjustment per diem is used solely to increase the compensation of facility employees. To be eligible, a facility must submit its plan for the salary distribution by December 31, 1998. If a

facility's plan for salary distribution is effective for its employees after July 1, 1998, the salary adjustment cost per diem is effective the same date as its plan.

D. Additional costs incurred by facilities as a result of this salary adjustment are not allowable costs for purposes of the September 30, 1998 cost report.

SECTION 12.000 DETERMINATION OF INTERIM AND SETTLE-UP OPERATING COST PAYMENT RATES

SECTION 12.010 **Conditions.** To receive an interim payment rate, a nursing facility must comply with the requirements and is subject to the conditions in Section 16.140, items A to C. The Department shall determine interim and settle-up operating cost payment rates for a newly constructed nursing facility, or one with an increase in licensed capacity of 50 percent or more according to Sections 12.020 and 12.030.

SECTION 12.020 **Interim operating cost payment rate.** Notwithstanding sections 8.000 through 11.000 that were effective until July 1, 1999 (or Section 8.010 that was effective until July 1, 2001), for the rate year or portion of an interim period beginning on or after July 1, 1987, the interim total operating cost payment rate must be determined according to Sections 1.000 to 15.000, except that:

A. The nursing facility must project its anticipated resident days for each resident class. The anticipated resident days for each resident class must be multiplied by the weight for that resident class as listed in Section 13.000 to determine the anticipated standardized resident days for the reporting period.

B. The Department shall use anticipated standardized resident days in determining the allowable historical case mix operating cost standardized per diem.

C. The Department shall use the anticipated resident days in determining both the allowable historical other care-related operating cost per diem and the allowable historical other operating cost per diem.

D. The annual adjustment factors determined in Section 10.010, must not be applied to the nursing facility's allowable historical per diems as provided in Sections 11.020 and 11.040.

E. The efficiency incentive in Section 11.040, items A or B, must not apply.

SECTION 12.030 **Settle-up operating cost payment rate.** The settle-up total operating cost payment rate must be determined according to items A to C.

A. The settle-up operating cost payment rate for interim periods before July 1, 1987, is subject to the rule parts that were in effect during the interim period.

B. To determine the settle-up operating cost payment rate for interim periods or the portion of an interim period occurring after July 1, 1987, subitems (1) to (7) must be applied.

(1) The standardized resident days as determined in Section 9.020 must be used for the interim period.

(2) The Department shall use the standardized resident days in subitem (1) in determining the allowable historical case mix operating cost standardized per diem.

(3) The Department shall use the actual resident days in determining both the allowable historical other care-related operating cost per diem and the allowable historical other operating cost per diem.

(4) The annual adjustment factors determined in Section 10.010 must not be applied to the nursing facility's allowable historical per diems.

(5) The efficiency incentive in Section 11.040, items A or B, must not apply.

C. For the nine-month period following the settle-up reporting period, the total operating cost payment rate must be determined according to item B except that the efficiency incentive as computed in Section 11.040, item A or B, applies.

D. The total operating cost payment rate for the rate year beginning July 1 following the nine-month period in item C must be determined under Sections 6.000 to 16.090.

E. A newly-constructed nursing facility or one with an increase in licensed capacity of 50 percent or more must continue to receive the interim total operating cost payment rate until the settle-up total operating cost payment rate is determined under this subpart.

SECTION 14.000 RESIDENT CLASSES, CLASS WEIGHTS AND RESIDENT ASSESSMENT SCHEDULES.

SECTION 14.010 **Resident classes** A. Effective January 1, 2012, resident classifications are based on the Minimum Data Set (MDS), version 3.0 assessment instrument, or its successor, mandated by the Centers for Medicare & Medicaid Services. The Department of Health establishes resident classes according to the 48-group, Resource Utilization Group, version IV (RUG IV) model. In addition to the 48-group RUG-IV classes, there are penalty and default classes. Resident classes are established based on the individual items on the MDS and must be completed according to the facility manual for case mix classification issued by the Department of Health.

B. Each resident must be classified based on the information from the MDS according to general domains as defined in the facility manual for case mix classification issued by the Department of Health.

SECTION 14.020 **Class weights.** The Department assigns a case mix index to each resident class based on the Centers for Medicare & Medicaid Services' staff time measurement study. An index maximization approach is used to classify residents. Residents are classified into the class for which they qualify that has the highest case mix value.

A. The Department assigns case mix indices to each resident class according to subitems (1) to (50).

(1) Class ES3, 3.00;

(2) Class ES2, 2.23;

(3) Class ES1, 2.22;

(4) Class RAE, 1.65;

(5) Class RAD, 1.58;

(6) Clas RAC, 1.36;

(7) Class RAB, 1.10;

(8) Class RAA, 0.82;

(9) Class HE2, 1.88;

(10) Class HE1, 1.47;

(11) Class HD2, 1.69;

(12) Class HD1, 1.33;

(13) Class HC2, 1.57;

(14) Class HC1, 1.23;

(15) Class HB2, 1.55;

(16) Class HB1, 1.22;

(17) Class LE2, 1.61;

(18) Class LE1,1.26;

(19) Class LD2, 1.54;

(20) Class LD1, 1.21;

(21) Class LC2, 1.30;

(22) Class LC1, 1.02;

(23) Class LB2, 1.21;

(24) Class LB1, 0.95;

(25) Class CE2, 1.39;

(26) Class CE1, 1.25;

(27) Class CD2, 1.29;

(28) Class CD1, 1.15;

(29) Class CC2, 1.08;

(30) Class CC1, 0.96;

(31) Class CB2, 0.95;

(32) Class CB1, 0.85;

(33) Class CA2, 0.73;

(34) Class CA1, 0.65;

(35) Class BB2, 0.81;

(36) Class BB1, 0.75;

(37) Class BA2, 0.58;

(38) Class BA1, 0.53;

(39) Class PE2; 1.25;

(40) Class PE1, 1.17;

(41) Class PD2, 1.15;

(42) Class PD1, 1.06;

(43) Class PC2, 0.91;

(44) Class PC1, 0.85;

(45) Class PB2, 0.70;

(46) Class PB1, 0.65;

(47) Class PA2, 0.49;

(48) Class PA1, 0.45;

(49) Class AAA, 0.45 (penalty);

(50) Class DDF, 1.00 (default).

SECTION 14.030 **Resident assessment schedule.** Nursing facilities must conduct and electronically submit to the Department of Health case mix assessments that conform to the assessment schedule defined in Code of Federal Regulations, title 42, section 483.20, and published by the Centers for Medicare & Medicaid Services in the Long Term Care Assessment Instrument User's Manual, version 3.0, and updates when issued by the Centers for Medicare and Medicaid Services. The Department of Health may substitute successor Centers for Medicare & Medicaid Services' manuals or question and answer documents to replace or supplement the current version of the manual or document.

A. The case mix assessments used for Minnesota's case mix classifications are:

(1) New admission assessments, which must be completed by day 14 following admission;

(2) Annual assessments, which must be completed within 366 days of the last comprehensive assessment;

(3) Significant change assessments, which must be completed within 14 days of the identification of a significant change; and

(4) Quarterly assessments, which must be completed following new admission assessments, annual assessments, and significant change assessments (if significant change assessments have been made). Each quarterly assessment must be completed within 92 days of the previous assessment.

B. (1) A facility must submit to the Department of Health an initial admission assessment for all residents who stay in the facility less than 14 days.

(2) Notwithstanding subitem (1), in lieu of submitting an initial admission assessment, a facility may elect to accept a default rate with a case mix index of 1.0 for all facility residents who stay less than 14 days. Residents with a stay of less than 14 days who are admitted to a nursing facility that makes this election for all stays of less than 14 days will be assigned a RUG case mix classification code of DDF.

(3) Nursing facilities must elect one of the options in subitems (1) and (2) with the Department of Health on an annual basis. The election will be effective on the following July 1.

C. Residents who are admitted and readmitted and leave the facility on a frequent basis and for whom readmission is expected may be discharged on an extended leave status. This status does not require reassessment each time the resident returns to the facility unless a significant change in the resident's status has occurred since the last assessment. The case mix classification for these residents is determined by the facility election made in item B.

D. (1) A facility that fails to complete or submit an assessment for a RUG-IV classification within seven days of the time requirements according to the schedule in item A is subject to a reduced rate for that resident. The resident for whom the facility failed to complete or submit an assessment within the time required will be assigned a RUG case mix classification code AAA. The reduced rate is the lowest rate for that facility. The reduced rate is effective on the day of admission for new admission assessments or on the day that the assessment was due for all other assessments and continues in effect until the first day of the month following the date of submission of the resident's assessment.

(2) If loss of revenue due to penalties incurred by a facility for any period of 92 days are equal to or greater than 1.0 percent of the total operating costs on the facility's most recent annual statistical and cost report, a facility may apply to the Commissioner of Human Services for a reduction in the total penalty amount. Effective August 1, 2017, a facility may apply to the Commissioner for a reduction in the penalty amount if loss of revenue is equal to or greater than .1 percent of total operating costs. The Commissioner of Human Services, in consultation with the Commissioner of Health, may, at the sole discretion of the Commissioner of Human Services, limit the penalty for residents covered by medical assistance to 15 days. Effective August 1, 2017, the Commissioner may limit the penalty to 10 days.

E. Resident reimbursement classifications will be effective:

(1) The day of admission for new admission assessments.

(2) The assessment reference date, which is the last day of the MDS observation period, for significant change assessments.

(3) The first day of the month following the assessment reference date for annual and quarterly assessments.

SECTION 14.040 **Rate determination upon transition to RUG-IV payment rates**

A. Effective January 1, 2012, the Department determines payment rates using the RUGS-IV based payment model in a facility-specific, budget-neutral manner. To transition from the current calculation methodology to the RUG-IV-based methodology nursing facilities reported to the Department the private pay and Medicaid resident days classified under both RUG-III and

RUG-IV for the six-month reporting period ending June 30, 2011. This report was submitted to the Department, in a form prescribed by the Department, by August 15, 2011. The Department used this data to compute the standardized days for the RUG-III and RUG-IV classification systems.

B. The Department determines the case mix adjusted component for the rate for services on or after January 1, 2012, as follows:

(1) using the September 30, 2010, cost report, determine the case mix portion of the operating cost for each facility;

(2) multiply the 36 operating payment rates in effect on December 31, 2011, by the number of private pay and Medicaid resident days assigned to each group for the reporting period ending June 30, 2011, and compute the total;

(3) compute the product of the amounts in clauses (1) and (2);

(4) determine the private pay and Medicaid RUG standardized days for the reporting period ending June 30, 2011, using the new indices calculated under section 14.020, item A.;

(5) divide the amount determined in clause (3) by the amount in clause (4), which shall be the default rate (DDF) unadjusted case mix component of the rate under the RUG-IV method; and

(6) determine the case mix adjusted component of each operating rate by multiplying the default rate (DDF) unadjusted case mix component by the case mix weight in section 14.020, item A. for each RUG-IV group.

C. The noncase mix components were allocated to each RUG group as a constant amount to determine the operating payment rate.

SECTION 15.000 RESIDENT ASSESSMENT

SECTION 15.010 **Assessment of nursing facility applicants and newly admitted residents.** Each nursing facility applicant or newly admitted resident must be assessed for the purpose of determining

the applicant's or newly admitted resident's case mix class.

A. The county long-term care consultation team or hospital screening team under contract with the county must assess all nursing facility applicants for whom preadmission screening is required and any applicant for whom a preadmission screening is not required but who voluntarily requests such a screening.

B. For an applicant whose admission to the nursing facility is for the purpose of receiving respite care services, preadmission screening is not required more than once every six months.

SECTION 15.020 **Change in resident class due to audits of assessments of nursing facility residents.** Any change in resident class due to a reclassification must be retroactive to the effective date of the assessment audited.

SECTION 15.030 **False information.** If the nursing facility knowingly supplies inaccurate or false information in an assessment or a request for reconsideration, the Department shall apply the penalties in Section 2.150.

SECTION 15.040 **Audit authority.** The Department of Health may audit assessments of nursing facility and boarding care home residents.

The audits may be conducted at the facility, and the Department of Health may conduct the audits on an unannounced basis.

SECTION 15.050 **Notice of resident reimbursement classification.** On an annual basis, a nursing facility must elect either item A or item B and notify the Department of Health of the election. If no election is made, item A is the default method to notify residents of their reimbursement classification. The election will be effective the following July 1.

A. The Department of Health generates a notice to inform each resident, and the nursing facility or boarding care home in which the resident resides, of the reimbursement classification established. The notice must inform the resident of the classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the Commissioner, and the opportunity to request a reconsideration of the classification. The notice must be sent by first-class mail. The notices are sent to the resident's nursing facility. The nursing facility is responsible for the distribution of the notice to each resident, to the person responsible for the payment of the resident’s nursing home expenses, or to another person designated by the resident. This notice must be distributed within three working days after the facility’s receipt of the notice.

B. A facility generates a classification notice, as prescribed by the Department of Health, to

each resident upon receipt of the confirmation of the case mix classification calculated by a facility or a corrected case mix classification as indicated on the final validation report from the Department of Health. The nursing facility is responsible for the distribution of the notice to each resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident. This notice must be distributed within three working days after the facility's receipt of the validation report from the Department of Health. If a facility elects this option, the Department of Health will provide the facility with a list of residents and their case mix classifications as determined by the Department of Health.

C. If a facility submits a correction to an assessment conducted under Section 14.030 that results in a change in case mix classification, the facility must give written notice to the resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident about the item that was corrected and the reason for the correction. The notice of corrected assessment may be provided at the same time that the resident, the person responsible for the payment of the resident's nursing home expenses, or another person designated by the resident is provided the resident's corrected notice of classification.

SECTION 15.060 **Request for reconsideration of classification.** The resident may request that the Commissioner reconsider the assigned reimbursement classification. The request must be submitted in writing within 30 days of the receipt of the notice. The documentation accompanying the reconsideration request is limited to documentation establishing that the needs of the resident at the time of the assessment resulting in the disputed classification justify a change of classification.

SECTION 15.070 **Facility's request for reconsideration.** In addition to the information in Section 15.060 a reconsideration request from a nursing facility must contain the following information: the date the notice was received by the facility; the date the notices were distributed to the resident; and a copy of the notice sent to the resident. This notice must tell the resident that a reconsideration of the classification is being requested, the reason for the request, that the resident's rate will change if the request is approved and the extent of the change, that copies of the facility's request and supporting documentation are available for review and that the resident also has the right to request a reconsideration. If the facility fails to provide this information with the reconsideration request, the request must be denied, and the facility may not make further reconsideration requests on that specific reimbursement classification.

SECTION 15.080 **Reconsideration.** The Commissioner's reconsideration must be made by individuals not involved in reviewing the assessment that established the disputed classification. The reconsideration must be based upon the initial assessment and upon the information provided to the Department. If necessary for evaluating the reconsideration request, the Department may conduct on-site reviews. In its discretion, the Department may review the reimbursement classifications assigned to all residents in the facility. Within 15 working days of receiving the request, the Department shall affirm or modify the original resident classification. The original classification

must be modified if the Department determines that the assessment resulting in the classification did not accurately reflect the needs of the resident at the time of the assessment. The resident and the nursing facility shall be notified within five working days after the decision is made. The Department's decision under this subdivision is the final administrative decision of the agency.

SECTION 15.090 **Change in resident class due to a request for reconsideration of resident classification.** Any change in a resident class due to a request for reconsideration of the classification must be made in accordance with items A and B.

A. The resident classification established by the Department of Health must be the classification that applies to the resident while any request for reconsideration is pending.

B. Any change in a resident class due to a reclassification must be effective as of the effective date of the classification established by the original assessment for which a reconsideration was requested.

SECTION 15.100 **Resident access to assessments and documentation.** The nursing facility must provide access to information regarding rates, assessments, and other documentation provided to the Department of Health in support of the resident's assessments to each nursing facility resident or the resident's authorized representative according to items A to D.

A. The nursing facility must post a notice of its current rates for each resident class in a conspicuous place. The rates must be posted no later than five days after receipt by the nursing facility. The nursing facility must include a notice that the nursing facility has chosen to appeal the rates.

B. The nursing facility must provide written notice to each private paying resident or the person responsible for payment of any increase in the total payment rate established by the Department 30 days before the increase takes effect. The notice must specify the current classification of the resident. This item does not apply to adjustments in rates due to a necessary change in the resident's classification as a result of an assessment required in this part.

C. The nursing facility must provide each nursing facility resident or the person responsible for payment with each classification letter received from the Department of Health within five days of the receipt of the classification letter. When the private paying resident is not the person responsible for payment, the classification letter must be sent to the person responsible for payment. If the resident's classification has changed, the nursing facility must include the current rate for the new classification with the classification letter.

D. Upon written request, the nursing facility must give the resident a copy of the assessment form and the other documentation that was given to the Department to support the assessment

findings. The nursing facility shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information.

SECTION 16.000 DETERMINATION OF THE PROPERTY-RELATED PAYMENT RATE

The appraised values determined under Sections 16.010 to 16.040 are not adjusted for sales or reorganizations of provider entities.

SECTION 16.010 **Initial appraised value.** For the rate year beginning July 1, 1985, and until August 31, 1992, the Department shall contract with a property appraisal firm which shall use the depreciated replacement cost method to determine the appraised value of each nursing facility participating in the medical assistance program as of June 30, 1985. The initial appraised value of each nursing facility and any subsequent reappraisal under Sections 16.020 and 16.030 must be limited to the value of buildings, attached fixtures, and land improvements used by the nursing facility and must be subject to the limits in Section 16.040.

For hospital-attached nursing facilities, the Department shall require the appraisal of those portions of buildings, attached fixtures, and land improvements in service areas shared between the nursing facility and the hospital. The appraised value of the shared service areas must be allocated between the nursing facility and the hospital or other nonnursing facility areas using the Medicare worksheet B-1 statistics in effect on September 30, 1984. The appraised value of the shared service areas must be allocated by stepdown placing the appraised values on the appropriate line of column 1 on the Medicare worksheet B. The appraised value of the shared service areas allocated to the nursing facility shall be added to the appraised value of the nursing facility's buildings, attached fixtures, and land improvements.

For a newly-constructed nursing facility applying to participate in the medical assistance program which commenced construction after June 30, 1985 and until August 31, 1992, or a nursing facility with an increase in licensed beds of 50 percent or more, the Department shall require an initial appraisal upon completion of the construction. The construction is considered complete upon issuance of a certificate of occupancy or, if no certification of occupancy is required, when available for resident use. The property-related payment rate is effective on the earlier of either the first day a resident is admitted or on the date the nursing facility is certified for medical assistance.

SECTION 16.020 **Routine updating of appraised value.** For rate years beginning after June 30, 1986 and until July 1, 1992, the Department shall routinely update the appraised value according to items A to C.

A. The Department shall contract with a property appraisal firm which shall use the depreciated replacement cost method to perform reappraisals. Each calendar year, the Department shall select a random sample of not less than 15 percent of the total number of nursing facilities participating in the medical assistance program as of July 1, of that year. The sample must not include nursing facilities receiving an interim payment rate under Section 16.140. All nursing facilities in the sample must be reappraised during the last six months of the calendar year. Incomplete additions or replacements must not be included in the reappraisals. An incomplete addition or replacement is one for which a certificate of occupancy is not yet issued, or if a certificate of occupancy is not required, the addition or replacement is not available for use.

The updated appraised value for hospital-attached nursing facilities resulting from a reappraisal of shared service areas must be allocated to the nursing facility in the same ratio indicated by the Medicare stepdown in effect on September 30 of the rate year in which the reappraisal is conducted. The method described in Section 16.010, is to be used to determine allocation of the updated appraised value. The reappraised value of the shared service areas allocated to the nursing facility must be added to the reappraised value of the nursing facility's buildings, attached fixtures, and land improvements.

B. The Department shall compute the average percentage change in appraised values for the nursing facilities in the sample. The appraised value of each nursing facility not in the sample, and not reappraised under Section 16.030, must be increased or decreased by the average percentage change subject to the limits in Section 16.040. No redetermination of the average percentage change in appraised values shall be made as a result of changes in the appraised value of individual nursing facilities in the sample made after the Department's computation of the average percentage change.

C. For hospital-attached nursing facilities not in the sample, the allocation of the appraised value of the shared service areas must be recomputed if the hospital involved experiences a cumulative change in total patient days as defined by the Medicare program of more than 15 percent from the reporting year in which the most recently used set of allocation statistics were determined. The allocation using the method described in Section 16.010 must be based on the Medicare stepdown in effect on September 30 of the rate year in which the updating of the appraised value is performed.

D. The adjustment to the property-related payment rate which results from updating the appraised value is effective for the rate year immediately following the rate year in which the updating takes place except as provided in Section 16.140.

E. Each calendar year that a random sample is selected in item A to compute the average percentage change in appraised values in item B, the Department shall evaluate the adequacy of the sample size according to subitems (1) to (6).

(1) The tolerance level for an acceptable error rate must be plus or minus three percentage points.

(2) The confidence level for evaluating the sample size must be 95 percent.

(3) The sample size required to be within the tolerance level in subitem (1) must be computed using standard statistical methods for determination of a sample size.

(4) If the required sample size in subitem (3) is greater than the sample size used in item A, additional appraisals must be performed until the number of appraisals is equal to the required sample size in subitem (3). The additional nursing facilities needed to complete the required sample size must be randomly selected. A nursing facility that is receiving a special reappraisal under Section 16.030, or one that is receiving an interim payment rate under Section 16.140, or one that was appraised in the original sample in item A must be excluded. The average percentage change in appraised values in item B must be recomputed based on the increased sample size in subitem (3).

(5) If the tolerance level in subitem (1) continues to be exceeded after applying the procedures in subitems (3) and (4), the procedures in subitems (3) and (4) must be repeated until the error rate is within the tolerance level.

(6) If the required sample size in subitem (3) is equal to or less than the sample size used in item A, the average percentage change in appraised values must be the percentage determined in item B.

SECTION 16.030 **Special reappraisals.** Special reappraisals are subject to the requirements of items A to F.

A. A nursing facility which makes an addition to or replacement of buildings, attached fixtures, or land improvements may request the Department to conduct a reappraisal upon project completion. A special reappraisal request must be submitted to the Department within 60 days after the project's completion date to be considered eligible for a special reappraisal. If a project has multiple completion dates or involves multiple projects, only projects or parts of projects with completion dates within one year of the completion date associated with a special reappraisal request can be included for the purpose of establishing the nursing facility's eligibility for a special reappraisal. A facility which is eligible to request, has requested, or has received a special reappraisal during the calendar year must not be included in the random sample process used to determine the average percentage change in appraised value of nursing facilities in the sample.

Upon receipt of a written request, the Department shall conduct a reappraisal within 60 days provided that all conditions of this section are met. The total historical cost of the addition or

replacement, exclusive of the proceeds from disposals of capital assets or applicable credits such as public grants and insurance proceeds, must exceed the lesser of $200,000 or ten percent of the most recent appraised value. The addition or replacement must be complete and a certificate of occupancy issued, or if a certificate of occupancy is not required, the addition or replacement must be available for use. Special reappraisals under this item are limited to one per 12-month period.

B. A nursing facility which retires buildings, attached fixtures, land improvements, or portions thereof without replacement, shall report the deletion to the Department within 30 days if the historical cost of the deletion exceeds $200,000. The Department shall conduct a reappraisal of the nursing facility to establish the new appraised value and adjust the property-related payment rate accordingly.

C. The adjusted property-related payment rate computed as a result of reappraisals in items A and B is effective on the first day of the month following the month in which the addition or replacement was completed or when the deletion occurred.

D. The Department shall reappraise every nursing facility at least once every seven calendar years following the initial appraisal. The Department shall reappraise a nursing facility if at the end of seven calendar years the nursing facility has not been reappraised at least once under Sections 16.020 or 16.030. The Department shall postpone the first seventh year catch-up reappraisals until the ninth year after the initial appraisal of all nursing facilities. The Department shall adjust the property-related payment rate to reflect the change in appraised value. The adjustment of the property-related payment rate is effective on the first day of the rate year immediately following the reappraisal.

E. The Department may require the reappraisal of a nursing facility within 60 days of receipt of information provided by the Minnesota Department of Health regarding the violation of standards and rules relating to the condition of capital assets.

F. Changes in the appraised value computed in this section must not be used to compute the average percentage change in Section 16.020, item B.

SECTION 16.035 **Appraisal sample stabilization.** The percent change in appraised values used for routine updating of appraised values shall be stabilized by eliminating from the sample of nursing facilities those appraisals that represent the five highest and the five lowest deviations from those nursing facilities previously established appraised values.

SECTION 16.040 **Determination of allowable appraised value.** A nursing facility's appraised value must be limited by items A to G.

A. The replacement cost new per bed limit for licensed beds in single bedrooms and multiple

bedrooms is determined according to subitems (1) to (4):

(1) For the rate year beginning July 1, 1992, the replacement-cost-new per bed limit must be $37,786 per licensed bed in multiple bedrooms and $56,635 per licensed bed in a single bedroom. After September 30, 1992, new projects which meet the requirements in Section 16.1374, item E, shall receive the replacement-cost-new per bed limits in that provision.

(2) The average historical cost per bed for depreciable equipment is computed by adding the historical cost of depreciable equipment for each nursing facility as determined in Section 16.100, item A and dividing the sum by the total number of licensed beds in those nursing facilities. The amount is then subtracted from the replacement cost new per bed limits determined in subitem (1).

(3) The differences computed in subitem (2) are the replacement cost new per bed limits for licensed beds in single bedrooms and multiple bedrooms effective for the rate year beginning on July 1, 1991.

(4) On each succeeding January 1, the Department will adjust the limit in subitem (1) and the depreciable equipment costs in subitem (2) by the percentage change in the composite index published by the Bureau of the Economic Analysis: Price indexes for Private Fixed Investments in Structures; Special Care for the two previous Octobers..

B. Each nursing facility's maximum allowable replacement cost new is determined annually according to subitems (1) to (3):

(1) The multiple bedroom replacement cost new per bed limit in item A must be multiplied by the number of licensed beds in multiple bedrooms.

(2) The single bedroom replacement cost new per bed limit in item A must be multiplied by the number of licensed beds in single bedrooms except as provided in Section 16.110, item C, subitem (2).

(3) The nursing facility's maximum allowable replacement cost new is the sum of subitems (1) and (2).

C. The nursing facility's replacement cost new determined in Sections 16.010 to 16.030 must be reduced by the replacement cost new of portions of the nursing facility used for functions whose costs are disallowed under Sections 1.000 to 19.050. Examples of such adjustments include non-nursing facility areas, or shared areas, therapy areas, day care areas, etc.

D. The adjusted replacement cost new is the lesser of item B or C.

E. The adjusted depreciation is determined by subtracting from the depreciation in Sections 16.010 to 16.030 the amount of depreciation, if any, related to the portion of the nursing facility's replacement cost new disallowed in item C or D.

F. The nursing facility's allowable appraised value is determined by subtracting the amount determined in item E from the amount in item D. If no adjustment to the replacement cost new is required in items C and D, then the nursing facility's allowable appraised value is the appraised value determined in Sections 16.010 to 16.030.

G. A nursing facility which has reduced licensed bed capacity after the preceding January 1, shall be allowed to aggregate the applicable replacement cost new per bed limits based on the number of beds licensed prior to the reduction; and establish capacity days for each rate year following the licensure reduction based on the number of beds licensed on the previous April 4. The notification must include a copy of the delicensure request that has been submitted to the Commissioner of health.

SECTION 16.050 **Allowable debt.** For purposes of determining the property-related payment rate, the Department shall allow or disallow debt according to items A to F.

A. Debt shall be limited as follows:

(1) Debt incurred for the purchase of land directly used for resident care and the purchase or construction of nursing facility buildings, attached fixtures, or land improvements or the capitalized replacement or capitalized repair of existing buildings, attached fixtures, or land improvements shall be allowed. Debt incurred for any other purpose shall not be allowed.

(2) Working capital debt shall not be allowed.

(3) An increase in the amount of a debt as a result of refinancing of capital assets which occurs after May 22, 1983, shall not be allowed except to the extent that the increase in debt is the result of refinancing costs such as points, loan origination fees, or title searches.

(4) An increase in the amount of total outstanding debt incurred after May 22, 1983, as a result of a change in ownership or reorganization of provider entities, shall not be allowed and the previous owner's allowable debt as of May 22, 1983, shall be allowed under item B.

(5) Any portion of the total allowable debt exceeding the appraised value as determined in Section 16.040 shall not be allowed.

(6) Any portion of a debt of which the proceeds exceed the historical cost of the

capital asset acquired shall not be allowed.

(7) Debt associated with the appraised value, is subtracted form each facility's appraised value and the result is multiplied by 5.66%. The facility's interest expense, as limited by floating and absolute maximum rates is added.

B. The nursing facility shall apportion debts incurred before October 1, 1984, among land and buildings, attached fixtures, land improvements, depreciable equipment and working capital by direct identification. If direct identification of any part of the debt is not possible, that portion of the debt which cannot be directly identified shall be apportioned to each component, except working capital debt, based on the ratio of the historical cost of the component to the total historical cost of all components. The portion of debt assigned to land and buildings, attached fixtures, and land improvements is allowable debt.

A hospital-attached nursing facility that has debts that are not directly identifiable to the hospital or the nursing facility shall allocate the portion of allowable debt computed according to Section 16.050, and allowable interest expense computed according to Section 16.070 assigned to land and buildings, attached fixtures, and land improvements using the Medicare stepdown method described in Section 16.010.

C. For debts incurred after September 30, 1984, the nursing facility shall directly identify the proceeds of the debt associated with specific land and buildings, attached fixtures, and land improvements, and keep records that separate such debt proceeds from all other debt. Only the debt identified with specific land and buildings, attached fixtures, and land improvements shall be allowed.

D. For reporting years ending on or after September 30, 1984, the total amount of allowable debt shall be the sum of all allowable debts at the beginning of the reporting year plus all allowable debts at the end of the reporting year divided by two. Nursing facilities which have a debt with a zero balance at the beginning or end of the reporting year must use a monthly average for the reporting year.

E. Except as provided in item F, debt incurred as a result of loans between related organizations must not be allowed.

F. Debt meeting the conditions in Section 16.132 is allowable.

SECTION 16.060 **Limitations on interest rates.** The Department shall limit interest rates according to items A to C.

A. Except as provided in item B, the effective interest rate of each allowable debt, including

points, financing charges, and amortization bond premiums or discounts, entered into after September 30, 1984, is limited to the lesser of:

(1) the effective interest rate on the debt; or

(2) 16 percent.

B. Variable or adjustable rates for allowable debt are allowed subject to item A. For each allowable debt with a variable or adjustable rate, the effective interest rate must be computed by dividing the interest expense for the reporting year by the average allowable debt computed under Section 16.050, item D.

C. For rate years beginning on July 1, 1985, and for rate years beginning after June 30, 1987, the effective interest rate for debts incurred before October 1, 1984, is allowed subject to item A.

SECTION 16.070 **Allowable interest expense.** The Department shall allow or disallow interest expense including points, finance charges, and amortization bond premiums or discounts under items A to G.

A. Interest expense is allowed only on the debt which is allowed under Section 16.050 and within the interest rate limits in Section 16.060.

B. A nonprofit nursing facility shall use its restricted funds to purchase or replace capital assets to the extent of the cost of those capital assets before it borrows funds for the purchase or replacement of those capital assets. For purposes of this item and Section 4.020, a restricted fund is a fund for which use is restricted to the purchase or replacement of capital assets by the donor or by the nonprofit nursing facility's board.

C. Construction period interest expense must be capitalized as a part of the cost of the building. The period of construction extends to the earlier of either the first day a resident is admitted to the nursing facility, or the date the nursing facility is certified to receive medical assistance recipients.

D. Interest expense for allowable debts entered into after May 22, 1983, is allowed for the portion of the debt which together with all outstanding allowable debt does not exceed 100 percent of the most recent allowable appraised value as determined in Sections 16.010 to 16.040. For a rate year beginning on or after July 1, 1989, the interest expense that results from a refinancing of a nursing facility's demand call loan, when the loan that must be refinanced was incurred before May 22, 1983, is an allowable interest expense.

E. Increases in interest expense after May 22, 1983, which are the result of changes in ownership or reorganization of provider entities, are not allowable.

F. Except as provided in item G, increases in total interest expense which are the result of refinancing of debt after May 22, 1983, are not allowed. The total interest expense must be computed as the sum of the annual interest expense over the remaining term of the debt refinanced.

G. Increases in total interest expense which result from refinancing a balloon payment on allowable debt after May 22, 1983, shall be allowed according to subitems (1) to (3):

(1) The interest rate on the refinanced debt shall be limited under Section 16.060, item A.

(2) The refinanced debt shall not exceed the balloon payment.

(3) The term of the refinanced debt must not exceed the term of the original debt computed as though the balloon payment did not exist.

SECTION 16.080 **Building capital allowance for owner-operated nursing facilities or nursing facilities with capital leases.** Except as provided in Section 16.140, for the rate years beginning after June 30, 1985, the building capital allowance for owner-operated nursing facilities or nursing facilities with capital leases must be computed as follows:

A. The rental factor is 5.33 percent. For the rate year beginning July 1, 1988 the rental factor will be increased by 6.2% rounded to the nearest 100th percent or 5.66 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 for the rate year beginning July 1, 1988.

B. The difference between the nursing facility's allowable appraised value determined under Sections 16.010 to 16.040 and the allowable debt determined in Section 16.050 is multiplied by the rental factor.

C. The amount determined in item B must be added to the total allowable interest expense determined under Sections 16.060 and 16.070.

D. Except as in item E, the amount determined in item C must be divided by 95 percent of capacity days.

E. If the average length of stay in the skilled level of care within a nursing facility is 180 days or less, the nursing facility shall divide the amount in item C by the greater of resident days or

80 percent of capacity days but in no event shall the divisor exceed 95 percent of capacity days.

For purposes of this item, the nursing facility shall compute its average length of stay for the skilled level of care by dividing the nursing facility's skilled resident days for the reporting year by the nursing facility's total skilled level of care discharges for that reporting year.

F. 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 are allowed in the computation of the lessee's building capital allowance, provided that reimbursement for these costs under an operating lease do not exceed the rate otherwise paid.

SECTION 16.090 **Building capital allowance for nursing facilities with operating leases.** Except as provided in Section 16.140, for rate years beginning after June 30, 1985, the building capital allowance for nursing facilities with operating lease costs incurred for buildings must be paid as determined by items A to C.

A. The allowable appraised value of the nursing facility must be established according to Sections 16.010 to 16.040.

B. The allowable interest expense determined under Sections 16.060 and 16.070 and the allowable debt determined under Section 16.050 for the leased nursing facility must be considered zero.

C. Except as in item D, the building capital allowance must be the lesser of the operating lease expense divided by 95 percent of capacity days, or the allowable appraised value multiplied by the rental factor and then divided by 95 percent of capacity days.

D. A nursing facility with an average length of stay of 180 days or less shall use the divisor determined in Section 16.080, item E, instead of 95 percent of capacity days.

SECTION 16.100 **Equipment allowance.** For rate years beginning after June 30, 1985, the equipment allowance must be computed according to items A to E.

A. The historical cost of depreciable equipment for nursing facilities which do not have costs for operating leases for depreciable equipment in excess of $10,000 during the reporting year ending September 30, 1984, is determined under subitems (1) and (2):

(1) The total historical cost of depreciable equipment reported on the nursing facility's audited financial statement for the reporting year ending September 30, 1984, must be multiplied by 70 percent. The product is the historical cost of depreciable equipment.

(2) The nursing facility may submit an analysis which classifies the historical cost of each item of depreciable equipment reported on September 30, 1984. The analysis must include an itemized description of each piece of depreciable equipment and its historical cost. The sum of the historical cost of each piece of equipment is the total historical cost of depreciable equipment for that nursing facility. For purposes of this item, a hospital-attached nursing facility shall use the allocation method in Section 16.010 to stepdown the historical cost of depreciable equipment.

B. The historical cost per bed of depreciable equipment for each nursing facility must be computed by dividing the total historical cost of depreciable equipment determined in item A by the nursing facility's total number of licensed beds on September 30, 1984.

C. All nursing facilities must be grouped in one of the following:

(1) nursing facilities with total licensed beds of less than 61 beds;

(2) nursing facilities with total licensed beds of more than 60 beds and less than 101 beds; or

(3) nursing facilities with more than 100 total licensed beds.

D. Within each group determined in item C, the historical cost per bed for each nursing facility determined in item B must be ranked and the median historical cost per bed established.

E. The median historical cost per bed for each group in item C as determined in item D must be increased by ten percent. For rate years beginning after June 30, 1986, this amount shall be adjusted annually by the percentage change indicated by the urban consumer price index for Minneapolis-Saint Paul, as published by the Bureau of Labor Statistics, new series index (1967=100) for the two previous Decembers.

F. The equipment allowance for each group in item C shall be the amount computed in item E multiplied by 15 percent and divided by 350.

G. For the rate year beginning July 1, 1990, the Commissioner shall increase the nursing facility's equipment allowance established in items A to F by $.10 per resident day.

H. 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 by the index in E.

SECTION 16.110 **Capacity days.** The number of capacity days is determined under items A to C.

A. The number of capacity days is determined by multiplying the number of licensed beds in the nursing facility by the number of days in the nursing facility's reporting period.

B. Except as in item C, nursing facilities shall increase the number of capacity days by multiplying the number of licensed single bedrooms by 0.5 and by the number of days in the nursing facility's reporting period. This adjustment has the effect of assigning a greater proportion of property costs to single bed rooms.

C. The Department shall waive the requirements of item B if a nursing facility agrees in writing to subitems (1) to (3).

(1) The nursing facility shall agree not to request a private room payment in Section 18.030 for any of its medical assistance residents in licensed single bedrooms.

(2) The nursing facility shall agree not to use the single bedroom replacement cost new limit for any of its licensed single bedrooms in the computation of the allowable appraised value in Section 16.040.

(3) The nursing facility shall agree not to charge any private paying resident in a single bedroom a payment rate that exceeds the amount calculated under clauses (a) to (c).

(a) The nursing facility's average total payment rate shall be determined by multiplying the total payment rate for each case mix resident class by the number of resident days for that class in the nursing facility's reporting year and dividing the sum of the resident class amounts by the total number of resident days in the nursing facility's reporting year.

(b) The nursing facility's maximum single bedroom adjustment must be determined by multiplying its average total payment rate calculated under clause (a) by ten percent.

(c) The nursing facility's single bedroom adjustment which must not exceed the amount computed in clause (b) must be added to each total payment rate established in Section 18.010 to determine the nursing facility's single bedroom payment rates.

SECTION 16.120 **Capitalization.** For rate years after June 30, 1985, the cost of purchasing or repairing capital assets shall be capitalized under items A to D.

A. The cost of purchasing a capital asset listed in the depreciation guidelines must be capitalized. The cost of purchasing any other capital asset not included in the depreciation guidelines must be capitalized if the asset has a useful life of more than two years and costs more than $500.

B. The nursing facility may consider as an expense a repair that costs $500 or less. Repairs that are considered as an expense must be classified in the plant operation and maintenance cost category. If the cost of a repair to a capital asset is $500 or more, and the estimated useful life of the capital asset is extended beyond its original estimated useful life by at least two years, or if the productivity of the capital asset is increased significantly over its original productivity, then the cost of the repair must be capitalized.

C. The property-related expenditures related to capital assets such as lease or depreciation, interest, and real estate taxes which are used by central, affiliated, or corporate offices must be classified in the nursing facility's general and administrative cost category.

D. Construction period interest expense, feasibility studies, and other costs related to the construction period must be capitalized.

SECTION 16.130 **Determination of the property-related payment rate.** The Department shall determine the property-related payment rate according to items A to G.

A. Except as provided in Section 16.140, the building capital allowance of each nursing home shall be added to the equipment allowance.

B. For rate years beginning after June 30, 1986, the historical property-related cost per diem shall be the property-related payment rate established for the previous rate year unless the nursing facility's capacity days change. If the nursing facility's capacity days change from one reporting year to the next for any reason including a change in the number of licensed nursing facility beds, a change in the election for computing capacity days as provided in Section 16.110, or a change in the number of days in the reporting year, the historical property related per diem must be recalculated using the capacity days for the reporting year in which the change occurred.

C. For rate years beginning after June 30, 1985, the property-related payment rate shall be the lesser of the amount computed in item A or the historical property-related per diem in item B increased by six percent for each rate year beginning July 1, 1985 through July 1, 1989, except as provided in items D to G.

D. A nursing facility whose allowable historical property-related per diem determined in item B is less than or equal to $2.25 shall receive a property related payment rate equal to the greater of $2.25 or its allowable historical property-related per diem increased by six percent for each rate year beginning July 1, 1985 through July 1, 1989, except that the property-related payment rate shall not exceed the amount determined in item A.

E. A nursing facility whose allowable historical property-related per diem determined in

item B is greater than the amount determined in item A shall receive a property-related payment rate equal to its allowable historical property-related per diem.

F. In the event of a change of ownership or reorganization of the provider entity occurring after June 30, 1985, the nursing facility's property-related payment rate must be the lesser of the property-related payment rate in effect at the time of sale or reorganization or the amount determined in item A. Changes in the property-related payment rate as a result of this item shall be effective on the date of the sale or reorganization of the provider entity. For the purposes of this subsection, the following types of transactions shall not be considered a sale or reorganization of a provider entity:

(1) The sale or transfer of a nursing facility upon death of an owner.

(2) The sale or transfer of a nursing facility due to serious illness or disability of an owner as defined under the social security act.

(3) The sale or transfer of the nursing facility upon retirement of an owner at 62 years of age or older.

(4) Any transaction in which a partner, owner, or shareholder acquires an interest or share of another partner, owner, or shareholder in a nursing facility business provided the acquiring partner, owner, or share has less than 50 percent ownership after the acquisition.

(5) A sale and leaseback to the same licensee which does not constitute a change in facility license.

(6) A transfer of an interest to a trust.

(7) Gifts or other transfers for no consideration.

(8) A merger of two or more related organizations.

(9) A transfer of interest in a facility held in receivership.

(10) A change in the legal form of doing business other than a publicly held organization which becomes privately held or vice versa.

(11) The addition of a new partner, owner, or shareholder who owns less than 20 percent of the nursing facility or the issuance of stock.

(12) An involuntary transfer including foreclosure, bankruptcy, or assignment for the

benefit of creditors.

G. The property-related payment rate for a nursing facility which qualifies for the special reappraisal in Section 16.030, item A shall be determined according to subitems (1) to (2).

(1) If the amount computed according to item A using the reappraised value is equal to or less than the property-related payment rate in effect prior to the reappraisal, the property-related payment rate in effect prior to the reappraisal shall not be adjusted.

(2) If the amount computed according to item A using the reappraised value is greater than the property-related payment rate in effect prior to the reappraisal, the property-related payment in effect prior to the reappraisal shall be added to the difference between the amount computed according to item A using the reappraised value and the amount value prior to the reappraisal. This sum must not exceed the amount computed in item A using the reappraised value. If the difference between the amount computed according to item A using the reappraised value and the amount computed according to item A using the most recent appraised value prior to the reappraisal is equal or less than zero, the difference shall be considered zero.

SECTION 16.132 **Special property-related payment provisions for certain leased nursing facilities.**

A. A nursing facility leased prior to January 1, 1986, and currently subject to adverse licensure action by the Minnesota Department of Health and whose ownership changes prior to July 1, 1990, shall be allowed a property payment rate equal to the lesser of its current lease obligation divided by its capacity days as outlined in Section 16.110, or the frozen property payment rate in effect for the rate year beginning July 1, 1989. For rate years beginning on or after July 1, 1991, the property related payment rate shall be its rental rate as computed using the previous owner's allowable principal and interest expense as allowed by the Minnesota Department of Human Services prior to that prior owner's sale and lease-back transaction of December 1985.

B. Notwithstanding other provisions in this attachment, a nursing facility licensed for 122 beds on January 1, 1998, and located in Columbia Heights has its property-related payment rate set under this section. The Department shall make a rate adjustment by adding $2.41 to the facility's July 1, 1997 property-related payment rate (which is effective for rate years beginning on or after July 1, 1998). The adjustment remains in effect so long as the facility's rates are set under this section. If the facility participates in the contractual alternative payment rate system of Section 22.000, the adjustment in this item is included in the facility's contract payment rate. If historical rates or property costs recognized under this section become the basis for future medical assistance payments to the facility under a managed care, capitation or other alternative payment system, the adjustment of this item will be included in the computation of the facility's payments.

SECTION 16.133 **~~Special property-related payment provisions for recently constructed nursing facilities.~~** ~~For the rate years beginning on or after July 1, 1990 nursing facilities that on or after January 1, 1976, but prior to January 1, 1987, were newly licensed after new construction, or increased their licensed beds by a minimum of 35 percent through new construction, and whose building capital allowance is less than their allowable annual principal and interest on allowable debt prior to the application of the replacement cost new per bed limit and whose remaining weighted average debt amortization schedule as of January 1, 1988, exceeded 15 years, must receive a property-related payment rate equal to the greater of their rental per diem or their annual allowable principal and allowable interest without application of the replacement cost new per bed limit divided by their capacity days from the preceding reporting year, plus their equipment allowance.~~

~~A nursing facility that is eligible for a property related payment rate under this section and whose property payment rate in a subsequent year is its rental per diem must continue to have its property related payment rates established for all future years based on the rental reimbursement formula. The Commissioner may require the nursing facility to apply for refinancing as a condition of receiving special rate treatment under this section. If a nursing facility is eligible for a property related payment rate under this section, and the nursing facility's debt is refinanced after October 1, 1988, the provisions of paragraphs (1) to (7) also apply to the property related payment rate for rate years beginning on or after July 1, 1990.~~

~~(1) A nursing facility's refinancing must not include debts with balloon payments.~~

~~(2) If the issuance costs, including issuance costs on the debt refinanced, are financed as part of the refinancing, the historical cost of capital asset limit includes issuance costs that do not exceed seven percent of the debt refinanced, plus related issuance costs. For purposes of this section, issuance costs means the fees charged by the underwriter, issuer, attorneys, bond raters, appraisers, and trustees, and includes the cost of printing, title insurance, registration tax, and a feasibility study for the refinancing of a nursing facility's debt. Issuance costs do not include bond premiums or discounts when bonds are sold at other than their par value, points, or a bond reserve fund. To the extent otherwise allowed under this paragraph, the straight-line amortization of the refinancing costs is not an allowable cost.~~

~~(3) The annual principal and interest expense payments and any required annual municipal fees on the nursing facility's refinancing replace those of the refinanced debt and, together with annual principal and interest payments on other allowable debts, are allowable costs subject to the limitation in subitem (2), if any.~~

~~(4) If the nursing facility's refinancing includes zero coupon bonds, the Commissioner shall establish a monthly debt service payment schedule based on an annuity that will produce an amount equal to the zero coupon bonds at maturity. The term and interest rate is the term~~

~~and interest rate of the zero coupon bonds. Any refinancing to repay the zero coupon bonds is not an allowable cost.~~

~~(5) The annual amount of the annuity payments is added to the nursing facility's allowable annual principal and interest expense payment computed in subitem (3).~~

~~(6) The property related payment rate is equal to the amount in subitem (5) divided by the nursing facility's capacity days as determined in Section 16.110, for the preceding reporting year plus an equipment allowance.~~

~~(7) Except as provided in this section, the previously outlined methodology for the calculation of property payment rates applies.~~

SECTION 16.136 **Property payment rates for rate years beginning on or after July 1, 1990.** For purposes of property-related reimbursement under this section, nursing facilities will be grouped according to the type of property related payment rate the Commissioner of Human Services for the rate year beginning July 1, 1989. A nursing facility whose property rate was determined under full rental shall be considered group A. A facility whose property payment rate was determined under phase down to rental reimbursement shall be considered group B. A facility whose rate was determined under the phase up provisions will be considered group C.

A. For the rate year beginning July 1, 1990, a group A facility will continue to have its property-related payment rate determined in accordance with the provisions of Section 16.080.

B. For the rate year beginning July 1, 1990, a group B facility will receive a payment related rate equal to the greater of:

(1) 87% of the property related payment rate in effect on July 1, 1989; or

(2) the rental per diem calculated in accordance with the provisions of Section 16.080 and this section; or

(3) the sum of 100% of the nursing facilities allowable principal and interest expense; plus its equipment allowance multiplied by the resident days for the reporting year ending September 30, 1989, divided by the nursing facilities capacity days.

C. For the rate year beginning July 1, 1990, a group C facility will have its property related payment rate calculated under the provisions of Section 16.130 item C and this section, except that its property related payment rate cannot exceed the lesser of its property related payment rate established for the rate year beginning July 1, 1989, multiplied by 116% or the rental per diem determined effective July 1, 1990.

D. The property related payment rate for a nursing facility that qualifies for a special reappraisal will have the applicable property related payment rate as calculated above and as adjusted in accordance with the provisions of Section 16.030.

E. Except as provided in Section 16.130, item F, and Section 16.132, a nursing facility that has a change of ownership or a reorganization of provider entity is subject to the provisions of Section 16.130, item F.

F. Except as provided in Section 16.133, a nursing facility will have its property related payment rate calculated according to items A to E. Those nursing facilities whose property related payment rates are calculated under the provisions of Section 16.133 will receive a property related payment rate equal to the greater of the rate calculated under Section 16.133 or that rate applicable under items A to E.

G. The following pertains to the property payment rate effective for nursing facilities that complete a moratorium exception project authorized by the state after March 1, 2020.

(1) A facility's limited URC is the lessor of:

(a) the facility's URC from the appraisal; or

(b) the product of (i) the number of the facility's licensed beds three months prior to the beginning of the rate year, (ii) the construction cost per square foot value, and (iii) 1,000 square feet.

(2) A facility's limited URC ratio is the facility's limited URC as determined in (1) divided by the facility's URC.

(3) A facility's limited DRC is the product of the facility's DRC and the facility's limited URC ratio as determined in (2).

(4) A facility's land and land improvement value is the facility's limited URC as determined in (1) multiplied by 0.05.

(5) A facility's annual fair rental value is the product of the sum of the facility's limited DRC as determined in (3) and the land and land improvement value as determined in (4); multiplied by the rental rate.

(6) A facility's fair rental value property rate is the quotient of the facility's annual fair rental value as determined in (5) divided by the product of the facility's capacity days and 0.88.

(7) A facility's equipment allowance rate is the quotient of the product of the equipment allowance per bed value, the facility's number of licensed beds, and the rental rate; divided by the product of the facility's capacity days and 0.88.

(8) Except as provided in (9)(a), a facility's total property payment rate is the sum of the facility's fair rental value property rate as determined in (6) and the facility's equipment allowance rate as determined in (7).

(9) A facility will not transition to the Fair Rental Value (FRV) property rate system

until after the completion of any project authorized through the state's moratorium exception process after March 1, 2020. The FRV rate will take effect the first day of the first month of the calendar quarter after the completion of the project described in paragraph.

(10) Upon a facility's transition to the fair rental value property rates, the facility's total property payment rate under (8) shall be the only payment for costs related to capital assets, including depreciation, interest and lease expenses for all depreciable assets, including moveable equipment, land improvements, and land. These facilities are ineligible for planned closure rate adjustments, consolidation rate adjustments, single-bed room incentives and the property rate inflation adjustment in section 22.060.

H. The following property rate definitions apply effective for rate years beginning on or after January 1, 2020.

(1) Addition. "Addition" means an extension, enlargement, or expansion of the nursing facility for the purpose of increasing the number of licensed beds or improving resident care.

(2) Appraisal. "Appraisal" means an evaluation of the nursing facility's physical real estate conducted by a property appraisal firm selected by the commissioner to establish the valuation of a building and fixed equipment. An appraisal does not include an evaluation of moveable equipment, land, or land improvements. An appraisal may include an evaluation of shared space provided the valuation is subsequently adjusted for any shared area included in the depreciated replacement cost and undepreciated replacement cost that is not used exclusively for nursing facility purposes.

(3) Building. "Building" means the physical plant and fixed equipment used directly for resident care in a licensed and Medicaid certified nursing home. Building excludes buildings or portions of buildings used by central, affiliated, or corporate offices.

(4) Capacity days. "Capacity days" means the number of licensed beds within the nursing facility multiplied by 365 days.

(5) Construction cost per square foot value. "Construction cost per square foot value" means the RSMeans nursing home cost per square foot of floor area for a 40,000 square foot nursing home with precast concrete and bearing walls multiplied by the commercial location factor for Minneapolis as indicated in the most recently available edition of the Square Foot Costs with RSMeans Data, as published by Gordian.

(6) Commercial valuation system. "Commercial valuation system" means the commercially available building valuation system selected by the commissioner for use in all appraisals.

(7) Depreciable movable equipment. "Depreciable movable equipment" means the standard movable care equipment and support service equipment generally used in

nursing facilities. Depreciable movable equipment includes equipment specified in the major movable equipment table of the depreciation guidelines.

(8) Depreciated replacement cost or DRC. "Depreciated replacement cost" or "DRC" means the depreciated replacement cost determined by an appraisal using the commercial valuation system selected by the commissioner. DRC excludes costs related to parking structures.

(9) Depreciation expense. "Depreciation expense" means the portion of a capital asset deemed to be consumed or expired over the life of the asset.

(10) Depreciation guidelines. "Depreciation guidelines" means the most recent publication of "Estimated Useful Lives of Depreciable Hospital Assets" issued by the American Hospital Association.

(11) Equipment allowance. "Equipment allowance" means the component of the property payment rate that is a payment for the use of depreciable movable equipment.

(12) Equipment allowance per bed value. The equipment allowance per bed value is $10,000 adjusted annually for rate years beginning on or after January 1, 2021, by the percentage change indicated by the urban consumer price index for Minneapolis-St. Paul, as published by the Bureau of Labor Statistics (series 1967=100) for the two previous Julys. The computation for this annual adjustment is based on the data that is publicly available on November 1 immediately preceding the start of the rate year.

(13) Fair rental value system. "Fair rental value system" means a system that establishes a price for the use of a space based on an appraised value of the property. The price is established without consideration of the actual accounting cost to construct or remodel the property. The price is the nursing facility value, subject to limits, multiplied by an established rental rate.

(14) Fixed equipment. "Fixed equipment" means equipment affixed to the building and not subject to transfer, including but not limited to wiring, electrical fixtures, plumbing, elevators, and heating and air conditioning systems.

(15) Land improvement. "Land improvement" means improvement to the land surrounding the nursing facility directly used for nursing facility operations as specified in the land improvements table of the depreciation guidelines, if replacement of the land improvement is the responsibility of the nursing facility. Land improvement includes construction of auxiliary buildings including sheds, garages, storage buildings, and parking structures. Parking structures are a land improvement and included only in the land and land improvement value. Parking structures are not to be included in either the undepreciated replacement cost or depreciated replacement cost.

(16) Rental rate. (a) "Rental rate" means the percentage applied to the allowable value of the building, moveable, and fixed equipment per year in the property payment rate calculation.

(17) The rental rate is the sum of the 20-year treasury bond rate as published in the Federal Reserve Bulletin using the average for the calendar year preceding the rate year based on data publicly available on November 1 each year, plus a risk value of three percent.

(18) Regardless of the result in paragraph (b), the rental rate must not be less than 7.5 percent or more than 12 percent.

(19) Shared area. "Shared area" means square footage that a nursing facility shares with a nonnursing facility operation to provide a support service. The appraisals initially may include the full value of all shared areas. The undepreciated replacement cost and depreciated replacement cost established by the appraisals must be adjusted in the final nursing facility values to reflect only the nursing facility usage. The adjustment must be based on a Medicare-approved allocation basis for the type of service provided by each area. Shared areas outside the appraised space must be added to DRC, URC, and related square footage using the average of each value from the space in the appraisal.

(20) Threshold project. "Threshold project" means additions to a building or fixed equipment that are subject to the threshold project limits described in section 16.1373, but are below the threshold described in section 16.1374, item F. Threshold project excludes land, land improvements, and depreciable movable equipment purchases.

(21) Undepreciated replacement cost or URC. "Undepreciated replacement cost" or "URC" means the undepreciated replacement cost determined by the appraisal for building and fixed equipment using the commercial valuation system and appraisal firm.

SECTION 16.1370 **Hold-harmless property-related rates.**

A. Terms used in Sections 16.1370 to 16.1378 shall be as defined in the plan. Capital assets for purposes of Sections 16.1370 to 16.1378 only means a nursing facility's buildings, attached fixtures, land improvements, leasehold improvements, and all additions to or replacements of those assets used directly for resident care.

B. Except as provided in this section, for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the property-related rate for a nursing facility shall be the greater of $4 or the property-related payment rate in effect on September 30, 1992. In addition, the incremental increase or decrease in the nursing facility's rental rate will be determined under this plan. An incremental decrease with an effective date after June 30, 1993, must reduce the nursing facility's property related payment rate.

C. Notwithstanding Section 16.130, item F, a nursing facility that has a sale permitted under Section 16.1371 after June 30, 1992, shall receive the property-related payment rate in effect at the time of the sale or reorganization. For rate periods beginning after October 1, 1992, a nursing facility

shall receive, in addition to its property-related payment rate in effect at the time of the sale, the incremental increase allowed under Section 16.1371. For rate years beginning after June 30, 1993, a nursing facility shall receive, in addition to its property-related payment rate in effect at the time of the sale, the incremental increase or decrease allowed under Section 16.1371.

D. For rate years beginning after June 30, 1993, the property-related rate for a nursing facility licensed after July 1, 1989 that was sold during the cost reporting year ending September 30, 1991 (after relocating its beds from a separate nursing home to a building formerly used as a hospital) is its property-related rate before the sale plus:

(1) the incremental increase effective October 1, 1992 of 29 cents per day; and

(2) any incremental increases after October 1, 1992 calculated by using its rental rate, recognizing the current appraised value of the facility at the new location, and including as allowable debt otherwise allowable debt incurred to remodel the facility in the new location before relocating its beds.

Section 16.1371 **Limitations on sales of nursing facilities.**

A. For rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility's property-related payment rate as established under Section 16.1370 shall be adjusted by either item B or C for the sale of the nursing facility, including sales occurring after June 30, 1992, as provided in this Section.

B. If the nursing facility's property-related payment rate under Section 16.1370 prior to sale is greater than the nursing facility's rental rate under this plan prior to sale, the nursing facility's property-related payment rate after sale shall be the greater of its property-related payment rate under Section 16.1370 prior to sale or its rental rate under this plan calculated after sale.

C. If the nursing facility's property-related payment rate under Section 16.1370 prior to sale is equal to or less than the nursing facility's rental rate under this plan prior to sale, the nursing facility's property-related payment rate after sale shall be the nursing facility's property-related payment rate under Section 16.1370 plus the difference between its rental rate calculated under this plan prior to sale and its rental rate calculated under this plan calculated after sale.

D. For purposes of this section, "sale" means the purchase of a nursing facility's capital assets with cash or debt. The term sale does not include a stock purchase of a nursing facility or any of the following transactions:

(1) a sale and leaseback to the same licensee that does not constitute a change in facility license;

(2) a transfer of an interest to a trust;

(3) gifts or other transfers for no consideration;

(4) a merger of two or more related organizations;

(5) a change in the legal form of doing business, other than a publicly held organization that becomes privately held or vice versa;

(6) the addition of a new partner, owner, or shareholder who owns less than 20 percent of the nursing home or the issuance of stock; and

(7) a sale, merger, reorganization, or any other transfer of interest between related organizations other than those permitted in this section.

E. For purposes of this item, "sale" includes the sale or transfer of a nursing facility to a close relative as defined in Section 1.030, upon the death of an owner, due to serious illness or disability, as defined under the Social Security Act, under 42 U.S.C. §423(d)(1)(A), or upon retirement of an owner from the business of owning or operating a nursing home at 62 years of age or older. For sales to a close relative allowed under this item otherwise nonallowable debt resulting from seller financing of all or a portion of the debt resulting from the sale shall be allowed and shall not be subject to Section 16.050, item E, provided that in addition to existing requirements for allowance of debt and interest, the debt is subject to repayment through annual principal payments and the interest rate on the related organization debt does not exceed three percentage points above the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation for delivery in 60 days in effect on the day of sale. If at any time the seller forgives the related organization debt allowed under this item for other than equal amount of payment on that debt, then the buyer shall pay to the State the total revenue received by the nursing facility after the sale attributable to the amount of allowable debt which has been forgiven. Any assignment, sale, or transfer of the debt instrument entered into by the close relatives, either directly or indirectly, which grants to the close relative buyer the rights to receive all or a portion of the payments under the debt instrument shall, effective on the date of the transfer, result in the prospective reduction in the corresponding portion of the allowable debt and interest expense. Upon the death of the close relative seller, any remaining balance of the close relative debt must be refinanced and such refinancing shall be subject to the provisions of Section 16.070, item G. This paragraph shall not apply to sales occurring on or after June 30, 1997.

F. For purposes of this section, "effective date of sale" means the later of either the date on which legal title to the capital assets is transferred or the date on which closing for the sale occurred.

G. The effective day for the property-related payment rate determined under this section shall be the first day of the month following the month in which the effective date of sale occurs or October 1, 1992, whichever is later.

H. Notwithstanding Section 16.050, item A, subitems (3) and (4), and Section 16.050, items E and F, the Commissioner shall limit the total allowable debt and related interest for sales occurring after June 30, 1992, to the sum of subitems (1) to (3):

(1) the historical cost of capital assets, as of the nursing facility's most recent previous effective date of sale or, if there has been no previous sale, the nursing facility's initial historical cost of constructing capital assets;

(2) the average annual capital asset additions after deduction for capital asset deletions, not including depreciations; and

(3) one-half of the allowed inflation on the nursing facility's capital assets. The Commissioner shall compute the allowed inflation as described in item I.

I. For purposes of computing the amount of allowed inflation, the Commissioner must apply the following principles:

(1) the lesser of the Consumer Price Index for all urban consumers or the Dodge Construction Systems Costs for Nursing Homes for any time periods during which both are available must be used. If the Dodge Construction Systems Costs for Nursing Homes becomes unavailable, the Commissioner shall substitute the index in Section 16.040, item A, subitem (4), or such other index as the secretary of the health care financing administration may designate;

(2) the amount of allowed inflation to be applied to the capital assets in item H, subitems (1) and (2), must be computed separately;

(3) the amount of allowed inflation must be determined on an annual basis, prorated on a monthly basis for partial years and if the initial month of use is not determinable for a capital asset, then one-half of that calendar year shall be used for purposes of prorating;

(4) the amount of allowed inflation to be applied to the capital assets in item H, subitems (1) and (2), must not exceed 300 percent of the total capital assets in any one of those clauses; and

(5) the allowed inflation must be computed starting with the month following the nursing facility's most recent previous effective date of sale or, if there has been no previous sale, the month following the date of the nursing facility's initial occupancy, and ending with the month

preceding the effective date of sale.

J. If the historical cost of a capital asset is not readily available for the date of the nursing facility's most recent previous sale or if there has been no previous sale for the date of the nursing facility's initial occupancy, then the Commissioner shall limit the total allowable debt and related interest after sale to the extent recognized by the Medicare intermediary after the sale. For a nursing facility that has no historical capital asset cost data available and does not have allowable debt and interest calculated by the Medicare intermediary, the Commissioner shall use the historical cost of capital asset data from the point in time for which capital asset data is recorded in the nursing facility's audited financial statements.

K. The limitations in this subdivision apply only to debt resulting from a sale of a nursing facility occurring after June 30, 1992, including debt assumed by the purchaser of the nursing facility.

SECTION 16.1372 **Capital repair and replacement cost reporting and rate calculation**.

For rate years beginning after June 30, 1993, a nursing facility's capital repair and replacement payment rate shall be established annually as provided in items A to E.

A. Notwithstanding Section 16.120, the costs of any of the following items, not included in the equity incentive computation under Section 16.1373 or reported as a capital asset addition under Section 16.375, item B, including cash payment for equity investment and principal and interest expense for debt financing, must be reported in the capital repair and replacement cost category when the cost of the item exceeds $500:

(1) wall coverings;

(2) paint;

(3) floor coverings;

(4) window coverings;

(5) roof repair; and

(6) window repair or replacement

B. Notwithstanding Section 16.120, the repair or replacement of a capital asset not included in the equity incentive computations under Section 16.1373 or reported as a capital asset addition under Section 16.1375, item B, must be reported in the capital repair and replacement cost category

when the cost of the item exceeds $500, or in the plant operations and maintenance cost category when the cost of the item is equal to or less than $500.

C. To compute the capital repair and replacement payment rate, the allowable annual repair and replacement costs for the reporting year must be divided by actual resident days for the reporting year. The annual allowable capital repair and replacement costs shall not exceed $150 per licensed bed. The excess of the allowed capital repair and replacement costs over the capital repair and replacement limit shall be a cost carryover to succeeding cost reporting periods, except that sale of a facility, under Section 16.1371, shall terminate the carryover of all costs except those incurred in the most recent cost reporting year. The termination of the carryover shall have effect on the capital repair and replacement rate on the same date as provided in Section 16.1371, item F, for the sale. For rate years beginning after June 30, 1994, the capital repair and replacement limit shall be subject to the index provided in Section 16.040, item A, subitem (4). For purposes of this section, the number of licensed beds shall be the number used to calculate the nursing facility's capacity days. The capital repair and replacement rate must be added to the nursing facility's total payment rate.

D. Capital repair and replacement costs under this Section shall not be counted as either care-related or other operating costs, nor subject to care-related or other operating limits.

E. If costs otherwise allowable under this section are incurred as the result of a project approved under the consolodation exception process or in connection with an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost of these assets exceeds the lesser of $150,000 or ten percent of the nursing facility's appraised value, these costs must be claimed under Sections 16.1373 or 16.1374 as appropriate.

SECTION 16.1373 **Major additions and replacements; equity incentive.** For rate years beginning after June 30, 1993, if a nursing facility acquires capital assets in connection with a project approved under the moratorium exception process or in connection with an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost of those capital asset additions exceeds the lesser of $150,000 or ten percent of the most recent appraised value, the nursing facility shall be eligible for an equity incentive payment rate as in items A to D. This computation is separate from the determination of the nursing facility's rental rate. An equity incentive payment rate as computed under this subdivision is limited to one in a 12-month period.

A. An eligible nursing facility shall receive an equity incentive payment rate equal to the allowable historical cost of the capital asset acquired, minus the allowable debt directly identified to that capital asset, multiplied by the equity incentive factor as described in items B and C and divided by the nursing facility's occupancy factor under Section 16.090, items C or D. This amount shall be added to the nursing facility's total payment rate and shall be effective the same day as the incremental increase in item D or Section 16.1374. The allowable historical cost of the capital assets

and the allowable debt shall be determined as provided in this plan.

B. The equity incentive factor shall be determined under subitems (1) to (4):

(1) divide the initial allowable debt in item A by the initial historical cost of the capital asset additions referred to in item A, then cube the quotient,

(2) subtract the amount calculated in subitem (1) from the number one,

(3) determine the difference between the rental factor and the lesser of two percentage points above the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation as published in the Wall Street Journal and in effect on the first day of the month the debt or cost is incurred, or 16 percent,

(4) multiply the amount calculated in subitem (2) by the amount calculated in subitem (3).

C. The equity incentive payment rate shall be limited to the term of the allowable debt in item A, not greater than 20 years nor less than ten years. If no debt is incurred in acquiring the capital asset, the equity incentive payment rate shall be paid for ten years. The sale of a nursing facility under Section 16.1371 shall terminate application of the equity incentive payment rate effective on the date provided in Section 16.1371, item F, for the sale.

D. A nursing facility with an addition to or a renovation of its buildings, attached fixtures, or land improvements meeting the criteria in this section and not receiving the property-related payment rate adjustment in Section 16.1374, shall receive the incremental change in the nursing facility's rental rate as determined under this plan. The incremental change shall be added to the nursing facility's property-related payment rate. The effective date of this incremental change shall be the first day of the month following the month in which the addition or replacement is completed. Effective for additions or replacements completed after January 1, 2018, the incremental change shall be effective on the first day of the month of January or July, whichever comes first, following the day on which the addition or replacement is completed.

E. Effective on and after March 1, 2020, a nursing facility that has completed a renovation, replacement, or upgrading project approved under the moratorium exception process will receive an estimate of the property payment rate to be established upon completion of the project and total state annual long-term costs of each moratorium exception proposal. The property rate estimate shall be based upon the estimated costs and total building valuation to be used in the total property payment rate calculation under section 16.136, G. For the purposes of determining the actual total property payment rate upon completion of the project, the final building valuation is the lesser of the limited depreciated replacement cost following a physical building appraisal or 105 percent of the estimated

total building valuation from the moratorium application.

SECTION 16.1374 **Special provisions for exceptions.**

A. Notwithstanding Section 16.030 for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility that has completed a renovation, replacement, or upgrading project approved under the moratorium exception process, or a nursing facility that has received a statutory exception after June 30, 1995, except for a 115 bed county owned nursing facility which has received a statutory exception in 1993, shall be reimbursed for costs directly identified to that project as provided in Section 16.1373 and this section.

B. Notwithstanding Section 16.050, item A, subitems (1) and (3), and Section 16.070, 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.

C. Debt incurred for costs under item B is not subject to Section 16.050, item A, subitems (5) or (6).

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

E. Notwithstanding Section 16.040, item A, subitem (4) for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the replacement-costs-new per bed limit to be used in Section 16.040, item B, for a nursing facility that has completed a renovation, replacement, or upgrading project that has been approved under the moratorium exception process or that has completed an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost exceeds the lesser of $150,000 or ten percent of the

most recent appraised value, must be $47,500 per licensed bed in multiple-bed rooms and $71,250 per licensed bed in a single-bed room. These amounts must be adjusted annually as specified in Section 16.040, item A, subitem (4) beginning January 1, 1993.

F. The Commissioner of the Minnesota Department of Health, in coordination with the Commissioner of the Minnesota Department of Human Services, shall deny each request for new licensed or certified nursing home or certified boarding care beds except as provided under the moratorium exceptions process. "Certified bed" means a nursing home bed or a boarding care bed certified by the Commissioner of health for the purposes of the medical assistance program under United States Code, title 42, sections 1396 et seq.

The Commissioner, in coordination with the Commissioner of the Minnesota Department of Health, shall deny any request to issue a nursing home license to a facility if that license would result in an increase in the medical assistance reimbursement amount.

In addition, the Commissioner of the Minnesota Department of Health must not approve any construction project whose costs exceed $1,000,000 plus inflation added annually unless:

(1) Any construction costs exceeding $1,000,000 are not added to the facility's appraised value and are not included in the facility's payment rate for reimbursement under the medical assistance program; or

(2) The project:

(a) has been approved through the moratorium exception process described in state law;

(b) meets an exception described in the moratorium exception state law;

(c) is necessary to correct violations of state or federal law issued by the Commissioner of the Minnesota Department of Health;

(d) is necessary to repair or replace a portion of the facility that was destroyed by fire, lightning, or other hazards provided that the provisions of statute governing replacement are met;

(e) as of May 1, 1992, the facility has submitted to the Commissioner of the Minnesota Department of Health written documentation evidencing that the facility meets the "commenced construction" definition as specified in Section 1.030, or that substantial steps have been taken prior to April 1, 1992, relating to the construction project. "Substantial steps" require that

the facility has made arrangements with outside parties relating to the construction project and has include the hiring of an architect or construction firm, submission of preliminary plans to the Department of Health or documentation from a financial institution that financing arrangements for the construction project have been made; or

(f) is being proposed by a licensed nursing facility that is not certified to participate in the Medical Assistance Program and will not result in new licensed or certified beds.

G. Prior to the final plan approval of any construction project, the Commissioner of the Minnesota Department of Health shall be provided with an itemized cost estimate for the project construction costs. If a construction project is anticipated to be completed in phases, the total estimated cost of all phases of the project shall be submitted to the Commissioner and shall be considered as one construction project. Once the construction project is completed and prior to the final clearance by the Commissioner of the Minnesota Department of Human Services, the total project construction costs for the construction project shall be submitted to the Commissioner. If the final project construction cost exceeds the dollar threshold in this subdivision, the Commissioner of Human Services shall not recognize any of the project construction costs or the related financing costs in excess of this threshold in establishing the facility's property-related payment rate.

~~Project construction costs includes the cost of new technology implemented as part of the construction project and depreciable equipment directly identified to the project, if the construction costs for facility capital asset additions, replacements, renovations, remodeling projects, construction site preparation costs and related soft costs are more than the threshold for additions and replacements in Section 16.1373. "Technology" means information systems or devices that make documentation, charting, and staff time more efficient or encourage and allow for care through alternative settings including touch screens, monitors, hand-helds, swipe cards, motion detectors, pagers, telemedicine, medication dispensers, and equipment to monitor vital signs and self-injections, and to observe skin and other conditions.~~

Technology and depreciable equipment are included in the project construction costs unless a written election is made by the facility, to not include it in the facility's appraised value. Debt incurred for purchase of technology and depreciable equipment is included as allowable debt for purposes of Section 16.050, items A and C, unless the written election is to not include it. Any new technology and depreciable equipment included in the project construction costs that the facility elects not to include in its appraised value and allowable debt is treated as provided in item B. Written election must be included in the facility's request for the rate change related to the project, and this election may not be changed.

The dollar thresholds for construction projects are as follows: for construction projects other than those authorized in item F, subitem (2), clauses (a) to (f), the dollar threshold is $1,000,000 plus inflation added annually. For projects authorized after July 1, 1993, under item F, subitem (2), clause

(a), the dollar threshold is the cost estimate submitted with a proposal for an exception to the state's moratorium law, plus inflation as calculated according to section 16.1378. For projects authorized under (b) to (d), the dollar threshold is the itemized estimate project construction costs submitted to the Commissioner of Health at the time of final plan approval, plus inflation as calculated according to Section 16.1378.

H. For purposes of this section, a total replacement means the complete replacement of the nursing facility's physical plant through the construction of a new physical plant, the transfer of the nursing facility's license from one physical plant location to another, or a new building addition to relocated beds from three- and four-bed wards.

(1) For total replacement projects completed on or after July 1, 1992, the incremental change in the nursing facility's rental per diem, for rate years beginning on or after July 1, 1995, shall be computed by replacing its appraised value, including the historical capital asset costs, and the capital debt and interest costs with the new nursing facility's allowable capital asset costs and the related allowable capital debt and interest costs.

(2) If the new nursing facility has decreased its licensed capacity, the aggregate replacement cost new per bed limit in Section 16.040, item G, shall apply.

(3) If the new nursing facility has retained a portion of the original physical plant for nursing facility usage, then a portion of the appraised value prior to the replacement must be retained and included in the calculation of the incremental change in the nursing facility's rental per diem. For purposes of this subitem, the original nursing facility means the nursing facility prior to the total replacement project. The portion of the appraised value to be retained shall be calculated according to clauses (a) to (c):

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

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

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

(4) In the case of either type of total replacement as authorized under statutory exceptions or moratorium process exceptions, the provisions of this subitem will also apply. For purposes of the moratorium exception authorized by statutory exception which permits the relocation of 117 beds from a 138 bed nursing home to a former hospital, if the total replacement involves the

renovation and use of an existing health care facility physical plant, the new allowable capital asset costs and related debt and interest costs shall include first the allowable capital asset costs and related debt and interest costs of the renovation, to which shall be added the allowable capital asset costs of the existing physical plant prior to the renovation, and if reported by the facility, the related allowable capital debt and interest costs.

I. Notwithstanding Section 16.110, item C, subitem (2), for a total replacement as defined in item H 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 22.061, the replacement-costs-new per bed limits are $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. Beginning January 1, 2000, these amounts must be adjusted annually as specified in item E. Effective June 5, 2012, construction projects approved under the moratorium exception process as defined in section 1.030 that are completed after August 30, 2010, shall be allowed the highest set of replacement-cost-new limits between the dates of project approval and project completion. Effective October 1, 2012, replacement-cost-new limits will be increased annually as specified in item E.

J. Notwithstanding Section 16.110, item C, subitem (2), for a total replacement as defined in item H, for a 96-bed nursing facility in Carlton county, the replacement costs new per bed limit for multiple-bed rooms, for semiprivate rooms with a fixed partition separating the resident beds, and for single rooms are the same as in item I. The resulting maximum allowable replacement costs new multiplied by 1.25 constitute the project's dollar threshold for purposes of application of the $1,000,000 plus inflation limit set forth in state law. The deadline for total replacement of this 96-bed nursing facility is May 31, 2000.

K. Notwithstanding Section 16.110, item C, subitem (2), for a total replacement as defined in item H involving a new building addition that relocates beds from three-bed wards for an 80-bed nursing home in Redwood county, the replacement costs new per bed limit for multiple-bed rooms, for semiprivate rooms with a fixed partition separating the resident beds, and for single rooms are the same as in item I. These amounts will be adjusted annually, beginning January 1, 2001. The resulting maximum allowable replacement costs new multiplied by 1.25 constitute the project's dollar threshold for purposes of application of the $1,000,000 plus inflation limit set forth in state law. If the other requirements in state law governing approval of requests for amendments to moratorium exception projects are met, the Department of Health may waive the requirement that the nursing facility's request for an amendment to its moratorium exception project design may not reduce the space in each resident's living area or in the total amount of common space devoted to resident and family uses by more than five percent.

L. For a renovation authorized under moratorium process exceptions for a 65-bed nursing home in St. Louis county, the incremental increase in rental rate for purposes of item D shall be

$8.16, and the total replacement cost, allowable appraised value, allowable debt, and allowable interest are increased according to the incremental increase.

M. Effective July 1, 2001, the Commissioner of the Minnesota Department of Health, in coordination with the Commissioner of the Minnesota Department of Human Services may:

(1) license and certify beds in nursing facilities that have undergone replacement or remodeling as part of a planned closure pursuant to Section 20.027;

(2) license and certify a total replacement project of up to 124 beds in facilities significantly damaged in the flood of 1997 when the damage was not apparent until years later. The operating cost payment rates for a new facility are determined pursuant to the interim and settle-up payment provisions of Section 12.000 and the payment provisions of this Attachment, except that Section 11.047, items A and B do not apply until the second rate year after the settle-up cost report is filed. Property-related payment rates are determined pursuant to this Attachment, taking into account any federal or state flood-related loans or grants provided to the facility;

(3) allow facilities that provide residential services for the physically handicapped with less than 60 beds to transfer nine beds to provide residential services, provided that the total number of licensed and certified beds does not increase;

(4) allow non-profit facilities in the county with the fewest beds per 1000 for age 65 and over that are not accepting beds from another closing non-profit facility to build replacement facilities of up to 120 beds, provided the new facility is located within four miles of the existing facility and is in the same county. Operating and property rates are determined pursuant to this Attachment, except that Section 11.047, items A and B do not apply until the second rate year after settle-up; and

(5) allow organizations that operate non-profit facilities in the county with the fewest beds per 1000 for age 65 and over to obtain up to 98 beds of a closing non-profit facility. All transferred beds will be put on layaway status, held in the name of the receiving facility. The layaway adjustment provisions of Section 20.100 do not apply. A receiving facility may only remove the beds from layaway for recertification and relicensure at the receiving facility's current site, or at a newly constructed facility located in Anoka County. A receiving facility must receive authorization before removing these beds from layaway status.

(6) effective July 1, 2006, allow an Anoka County nursing facility that had placed beds on layaway status as part of a previous statutory exception to the moratorium to remove beds from that status if the removal is part of a project approved by the commissioner of Human Services under the competitive moratorium exception process.

N. Effective July 1, 2003, the Department of Health, in coordination with the Department of Human Services, may approve the renovation, replacement, upgrading, or relocation of facilities that meet the following conditions:

(1) license and certify 80 beds in city-owned facilities to be constructed on the site of new city-owned hospitals that replace existing 85-bed facilities attached to existing hospitals. The threshold allowed is the amount that was allowed under the moratorium exception process; and

(2) license and certify 29 beds to be added to 69-bed facilities, provided that:

(a) the 29 beds are transferred from active or layaway status from facilities that have 235 beds on April 1, 2003, when both facilities are located in the same county; and

(b) the licensed capacity of 235-bed facilities must be reduced to 206 beds, and the payment rate will not be adjusted as a result of the transfer.

The operating payment rate of 69-bed facilities adding 29 beds after completion of a project will be the same as it was on the day before the day the beds are licensed and certified. Projects will not begin unless they are approved and financed under the moratorium exception process.

O. Effective August 1, 2004, the Department of Health, in coordination with the Department of Human Services, may approve the renovation, replacement, upgrading, or relocation of facilities that meet the following conditions:

(1) license and certify 60 new beds, provided that:

(a) 45 of the new beds are transferred from facilities that have 45 beds in the same county under common ownership that have closed, and 15 of the new beds are transferred from facilities that have 182 beds under common ownership;

(b) the Department continues to have authority under Section 20.027 to negotiate budget-neutral planning facility closures; and

(c) money is available from planned closures of facilities under common ownership to make implementation of this item budget-neutral.

The bed capacity of the 182-bed facilities under common ownership is reduced to 167 beds following the transfer.

P. Effective July 1, 2006, the Department of Health, in coordination with the Department of Human Services, may license and certify up to 80 beds transferred from an existing state-owned nursing facility in a county to a new facility located on the grounds of the existing state-owned facility from which they are transferred. The operating cost payment rates for the new facility shall be determined based on the interim and settle up payment provisions of Section 12.000 and the reimbursement provisions of Sections 1.000 through 21.000. The property payment rate for the first three years of operation shall be $35 per day. For subsequent years, the property payment rate of $35 shall be adjusted for inflation as provided in section 22.060 so long as the facility has a contract under Section 22.000.

Q. Effective for rate adjustments beginning July 1, 2006, nursing facilities paid by the prospective rate-setting methodology described in Sections 1.000 through 21.000 that commenced a construction project on or after October 1, 2004, and do not have a contract under the contractual rate-setting methodology described in Section 22.000 by September 30, 2006, are eligible to request a property rate adjustment under Section 16.000 through September 30, 2006. If the request results in the commissioner determining a rate adjustment is allowable, the rate adjustment is effective on the first of the month following project completion. These facilities shall be allowed to accumulate construction project costs for the period October 1, 2004, to September 30, 2006.

R. Upon Steele County completing asset transfers and constructing a new nursing facility, its present nursing facility will be allowed to relocate 80 beds. For the first three years of operation of the new facility, the property payment rate shall be increased by an amount as calculated according to items (i) to (v):

(i) compute the estimated decrease in medical assistance residents served by the nursing facility by multiplying the decrease in licensed beds by the historical percentage of medical assistance resident days;

(ii) compute the annual savings to the medical assistance program from the delicensure of 28 beds by multiplying the anticipated decrease in medical assistance residents, determined in item (i), by the existing facility's weighted average payment rate multiplied by 365;

(iii) compute the anticipated annual costs for community-based services by multiplying the anticipated decrease in medical assistance residents served by the nursing facility, determined in item (i), by the average monthly elderly waiver service costs for individuals in Steele County multiplied by 12;

(iv) subtract the amount in item (iii) from the amount in item (ii);

(v) divide the amount in item (iv) by an amount equal to the relocated nursing facility's occupancy factor as determined in section 16.080, multiplied by the historical percentage of medical assistance resident days.

For subsequent years, the property payment rate shall be adjusted for inflation as provided in section 22.060 so long as the facility has a contract under Section 22.000.

S. Effective July 1, 2008, a nursing facility providing specialty care in Minneapolis may close and relocate beds to a new facility in Robbinsdale under common ownership if approved under the moratorium exception at Minnesota Statutes (2008) §144.073.

T. Effective May 14, 2010, nursing facility bed consolidation and relocation with integration of these services with other community-based services under a Communities-for-a-Lifetime pilot program is allowed for a new site in Goodhue County. These changes will have a comprehensive plan to create innovative responses to the aging population. Two nursing facilities, one for 84 beds and one for 65 beds, in the city of Red Wing licensed on July 1, 2015, shall be consolidated into a newly renovated 64-bed nursing facility resulting in the delicensure of 85 beds. The closure of the 85 beds shall not be eligible for a planned closure rate adjustment under section 20.027. The construction project permitted in this clause shall not be eligible for a threshold project rate adjustment under section 22.061. The payment rate for external fixed costs shall be increased by an amount as calculated according to items (i) to (vi):
(i) compute the estimated decrease in medical assistance residents served by both nursing facilities by multiplying the difference between the occupied beds of the two nursing facilities for the reporting year ending September 30, 2009, and the projected occupancy of the facility at 95 percent occupancy by the historical percentage of medical assistance resident days;
(ii) compute the annual savings to the medical assistance program from the delicensure by multiplying the anticipated decrease in the medical assistance residents, determined in item (i), by the hospital-owned nursing facility weighted average payment rate multiplied by 365. The hospital-owned nursing facility weighted average payment rate is determined by multiplying the facility's current total payment rates for each of the 36 RUG payment levels by the corresponding total resident days according to the most recently desk-audited cost report. Sum the products of these calculations and the resident days. Divide the sum of the products by the sum of the resident days to compute the weighted average payment rate;
(iii) compute the anticipated annual costs for community-based services by multiplying the anticipated decrease in medical assistance residents served by the facilities, determined in item (i), by the average monthly elderly waiver service costs for individuals in Goodhue County multiplied by 12;
(iv) subtract the amount in item (iii) from the amount in item (ii);
(v) multiply the amount in item (iv) by 57.2 percent; and
(vi) divide the difference of the amount in item (iv) and the amount in item (v) by an amount

equal to the relocated nursing facility's occupancy factor under section 16.080, items D & E, multiplied by the historical percentage of medical assistance resident days.

U. Effective June 28, 2011, a 137-bed nursing facility in Bloomington that applied for and was selected for a moratorium exception project is allowed to increase its moratorium-exception project rate adjustment from $14.42 to $19.33.

V. Effective July 1, 2013, a 110-bed facility in McLeod County will receive a property-rate increase, based on the methodology in Section 22.061, by having its replacement-cost-new limit under Section 16.1374 I adjusted to allow $1,129,463 of a completed construction project to increase the property payment rate.

W. Effective July 1, 2013, a 61-bed facility in Dakota County will receive a property-rate increase, based on the methodology in Section 22.061, by having its replacement-cost-new limit under Section 16.1374 I adjusted to allow $1,407,624 of a completed construction project to increase the property payment rate. Effective September 1, 2013 or later, the facility will receive a property-rate increase, based on the methodology in Section 22.061, by having its replacement-cost-new limit under Section 16.1374 I adjusted to allow $1,244,599 of a completed construction project to increase the property rate.

X. Effective July 1, 2013, or later, any boarding care facility in Hennepin County licensed for 101 beds shall be allowed to receive a property rate adjustment, based on the methodology in Section 22.061, for a construction project that takes action to come into compliance with Minnesota Department of Labor and Industry elevator upgrade requirements, with costs below the minimum threshold under Section 16.1374 E. Only costs related to the construction project that brings the facility into compliance with the elevator requirements shall be allowed.

Y. Effective July 1, 2015, replacement projects are allowed for a total of up to 129 beds from a nursing facility located in Polk County that was destroyed by flood in 1997. At least 25 beds will be located in Polk County and up to 104 beds may be distributed among no more than three other counties with fewer than the median number of age intensity adjusted beds per thousand, subject to approval by the commissioner of health. The Department will determine payment rates based on interim, settle-up and property payment provisions in Sections 12, 16, 22 and 23. If replacement beds are combined with beds from existing nursing facilities, the Department will calculate payment rates using the weighted average of rates from this paragraph and Section 20.120.

Z. Effective July 1, 2015, upon project completion, the Department shall increase the payment rate described in Section 22.061 by $12.50, for a facility approved in 2015 under the nursing facility moratorium exception process with at least 150, but not more than 160 active beds as of January 1, 2015.

AA. Effective July 1, 2015, upon project completion, the Department shall increase the payment rate described in Section 22.061 by $4.00, for a facility approved in 2015 under the nursing facility moratorium exception process with at least 120, but not more than 149 active beds as of January 1, 2015.

SECTION 16.1375 **Appraisals; updating appraisals, additions, and replacements.**

A. Notwithstanding Sections 16.010 to 16.030, the appraised value, routine updating of the appraised value, and special reappraisals are subject to this section.

B. Notwithstanding Section 16.020, for rate years beginning after June 30, 1993, the Commissioner shall routinely update the appraised value of each nursing facility by adding the cost of capital asset acquisitions to its allowable appraised value. The Commissioner shall also annually index each nursing facility's allowable appraised value by the inflation index referenced in Section 16.040, item A, subitem (4), for the purpose of computing the nursing facility's annual rental rate. In annually adjusting the nursing facility's appraised value, the Commissioner must not include the historical cost of capital assets acquired during the reporting year in the nursing facility's appraised value. In addition, the nursing facility's appraised value must be reduced by the historical cost of capital asset disposals or applicable credits such as public grants and insurance proceeds. Capital asset additions and disposals must be reported on the nursing facility's annual cost report in the reporting year of acquisition or disposal. The incremental increase in the nursing facility's rental rate resulting from this annual adjustment shall be added to the nursing facility's property-related payment rate for the rate year following the reporting year.

C. For rate years beginning on or after January 1, 2020, the commissioner shall select a commercial valuation system that property appraisal firms selected by the commissioner must utilize for all nursing facility property appraisals. The commissioner shall use appraisal reports produced by commissioner-selected appraisal firms using the commissioner-selected commercial valuation system for the purposes of rate setting the property rate under the Fair Rental Value system in section 16.136, G. The commissioner shall not adjust or substitute any alternative appraisal of properties.

1. The property appraisal firm selected by the commissioner shall determine the appraised valuation of a building and fixed equipment. The appraisal firm shall not include depreciable movable equipment, land, land improvements, or the physical plant for central office operations in the appraised valuation of the nursing facility. Appraisals are not intended to exactly reflect market value. Appraisal firms selected by the commissioner shall produce a report detailing both the DRC and URC of the nursing facility.
2. Selected appraisal firms may include the full value of all shared areas in an initial appraisal but must adjust the nursing facility valuation of any shared area included in the square footage, DRC, and URC that are not used for nursing facility purposes to

reflect only the nursing facility usage of shared areas. Selected appraisal firms shall adjust facility valuation for shared areas using a Medicare-approved allocation basis for the type of service provided in each area. Shared areas outside the appraised space must be added to the DRC, URC, and related square footage using the average of each value from the space in the appraisal.

3. A nursing facility may appeal a finding of fact in the appraisal report to the appraiser within 20 calendar days after receipt of the appraisal report and request revision.
4. When a facility's most recent physical appraisal was completed more than 12 months before the start of the rate year, the appraisal firm shall use the commercial valuation system to update the most recent DRC and URC of the nursing facility and the commissioner shall use the updated DRC and URC to determine the total property payment rate under section 256R.26. Updated DRC and URC are updates only and not subject to revisions of any of the original valuations or appeal to the appraiser by the facility.
5. After a facility's initial rate year the commissioner shall ensure that a selected appraisal firm conducts a new physical appraisal of the facility at least once every three years using a commercial valuation system.
6. After the initial rate year the increase in the URC for each subsequent appraisal shall not exceed $2,000 per bed per year since the most recent physical appraisal, plus any approved threshold projects completed since the most recent appraisal. Any limitation to the URC must be applied in the same proportion to the DRC. The commissioner shall update annually on January 1 the per-bed per-year limit on the increase in the URC in this subdivision by the annual percent change in the construction cost per square foot value.

Section 16.1376 **Refinancing incentive.**

A. A nursing facility that refinances debt after May 30, 1992, in order to save in interest expense payments as determined in subitems (1) to (5) may be eligible for the refinancing incentive under this Section. To be eligible for the refinancing incentive, a nursing facility must notify the Commissioner in writing of such a refinancing within 60 days following the date on which the refinancing occurs. If the nursing facility meets these conditions, the Commissioner shall determine the refinancing incentive as in subitems (1) to (5).

(1) Compute the aggregate amount of interest expense, including amortized issuance and financing costs, remaining on the debt to be refinanced, and divide this amount by the number of years remaining for the term of that debt.

(2) Compute the aggregate amount of interest expense, including amortized issuance

and financing costs, for the new debt, and divide this amount by the number of years for the term of that debt.

(3) Subtract the amount in subitem (2) from the amount in subitem (1), and multiply the amount, if positive, by .5.

(4) The amount in subitem (3) shall be divided by the nursing facility's occupancy factor under Section 16.090, items C or D.

(5) The per diem amount in subitem (4) shall be deducted from the nursing facility's property-related payment rate for three full rate years following the rate year in which the refinancing occurs. For the fourth full rate year following the rate year in which the refinancing occurs, and each rate year thereafter, the per diem amount in subitem (4) shall again be deducted from the nursing facility's property-related payment rate.

B. An increase in a nursing facility's debt for costs in Section 16.1375, item B, subitem (2), including the cost of refinancing the issuance or financing costs of the debt refinanced resulting from refinancing that meets the conditions of this section shall be allowed, notwithstanding Section 16.050, item A, subitem (6).

C. The proceeds of refinancing may not be used for the purpose of withdrawing equity from the nursing facility.

D. Sale of a nursing facility under Section 16.1371 shall terminate the payment of the incentive payments under this section effective the date provided in Section 16.1371, item F, for the sale, and the full amount of the refinancing incentive in item A shall be implemented.

E. If a nursing facility eligible under this section fails to notify the Commissioner as required, the Commissioner shall determine the full amount of the refinancing incentive in item A, and shall deduct one-half that amount from the nursing facility's property-related payment rate effective the first day of the month following the month in which the refinancing is completed. For the next three full rate years, the Commissioner shall deduct one-half the amount in item A, subitem (5). The remaining per diem amount shall be deducted in each rate year thereafter.

F. The Commissioner shall reestablish the nursing facility's rental rate following the refinancing using the new debt and interest expense information for the purpose of measuring future incremental rental increases.

SECTION 16.1377 **Special property rate setting**.
For rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the property-related payment rate for a nursing facility approved for total replacement under the moratorium exception process through an addition to another nursing facility shall have its

property-related rate under Section 16.1370 recalculated using the greater of actual resident days or 80 percent of capacity days. This rate shall apply until the nursing facility is replaced or until the moratorium exception authority lapses, whichever is sooner.

SECTION 16.1378 **Indexing thresholds.** Beginning January 1, 1993, and each January 1 thereafter, the Commissioner shall annually update the dollar thresholds in Sections 16.1373, and 16.1374, by the inflation index referenced in Section 16.090, item A, subitem (4).

SECTION 16.138 **Plant and maintenance costs.** For the rate years beginning on or after July 1, 1987, the Department shall allow as an expense in the reporting year of occurrence the lesser of the actual allowable plant and maintenance costs for supplies, minor equipment, equipment repairs, building repairs, purchased services and service contracts, except for arms-length service contracts whose primary purpose is supervision, or $325 per licensed bed.

SECTION 16.140 **Determination of interim and settle-up payment rates.** The Department shall determine interim and settle-up payment rates according to items A to J, and for rate years beginning on or after January 1, 2020, according to item K for threshold projects and item L for newly constructed nursing facilities.

A. A newly-constructed nursing facility, or one with a capacity increase of 50 percent or more, may submit a written application to the Department to receive an interim payment rate. The nursing facility shall submit cost reports and other supporting information as required in Sections 1.000 to 19.050 for the reporting year in which the nursing facility plans to begin operation at least 60 days before the first day a resident is admitted to the newly-constructed nursing facility bed. The nursing facility shall state the reasons for noncompliance with Sections 1.000 to 19.050. The effective date of the interim payment rate is the earlier of either the first day a resident is admitted to the newly-constructed nursing facility or the date the nursing facility bed is certified for medical assistance. The interim payment rate for a newly-constructed nursing facility, or a nursing facility with a capacity increase of 50 percent or more, is determined under items B to D.

B. The interim payment rate must not be in effect more than 17 months. When the interim payment rate begins between May 1 and September 30, the nursing facility shall file settle-up cost reports for the period from the beginning of the interim payment rate through September 30 of the following year. When the interim payment rate begins between October 1 and April 30, the nursing facility shall file settle-up cost reports for the period from the beginning of the interim payment rate to the first September 30 following the beginning of the interim payment rate.

C. The interim payment rate for a nursing facility which commenced construction prior to July 1, 1985, is determined under the temporary rule then in effect, except that capital assets must be classified under Sections 1.000 to 19.050.

D. The interim property-related payment rate for a nursing facility which commences construction after June 30, 1985, is determined as follows:

(1) At least 60 days before the first day a resident is admitted to the newly-constructed nursing facility bed and upon receipt of written application from the nursing facility, the Department shall establish the nursing facility's appraised value according to Sections 16.010 and 16.040.

(2) The nursing facility shall project the allowable debt and the allowable interest expense according to Sections 16.050 and 16.070.

(3) The interim building capital allowance must be determined under Section 16.080 or 16.090.

(4) The equipment allowance during the interim period must be the equipment allowance computed in accordance with Section 16.100 which is in effect on the effective date of the interim property-related payment rate.

(5) The interim property-related payment rate must be the sum of subitems (3) and (4).

(6) Anticipated resident days may be used instead of 95% percent capacity days.

E. The settle-up property-related payment rate and the property-related payment rate for the nine months following the settle-up for a nursing facility which commenced construction before July 1, 1985, is determined under the temporary rule then in effect. The property-related payment rate for the rate year beginning July 1 following the nine-month period is determined under Sections 16.000 to 16.140.

F. The settle-up property-related payment rate for a nursing facility which commenced construction after June 30, 1985, shall be established as follows:

(1) The appraised value determined in item D, subitem (1) must be updated in accordance with Section 16.020, item B prorated for each rate year, or portion of a rate year, included in the interim payment rate period.

(2) The nursing facility's allowable debt, allowable interest rate, and allowable interest expense for the interim rate period shall be computed in accordance with Sections 16.050, 16.060, and 16.070.

(3) The settle-up building capital allowance shall be determined in accordance with Section 16.080 or 16.090.

(4) The equipment allowance shall be updated in accordance with Section 16.100 prorated for each rate year, or portion of a rate year, included in the interim payment rate period.

(5) The settle-up property-related payment rate must be the sum of subitems (3) and (4).

(6) Resident days may be used instead of 95% percent capacity days.

G. The property-related payment rate for the nine months following the settle-up for a nursing facility which commenced construction after June 30, 1985, shall be established in accordance with item F except that 95% percent capacity days must be used.

H. The property-related payment rate for the rate year beginning July 1 following the nine-month period in item G must be determined under this section.

I. A newly-constructed nursing facility or one with a capacity increase of 50 percent or more must continue to receive the interim property-related payment rate until the settle-up property-related payment rate is determined under this section.

J. The interim real estate taxes and special assessments payment rate shall be established using the projected real estate taxes and special assessments cost divided by anticipated resident days. The settle-up real estate taxes and special assessments payment rate shall be established using the real estate taxes and special assessments divided by resident days. The real estate and special assessments payment rate for the nine months following the settle-up shall be equal to the settle-up real estate taxes and special assessments payment rate.

K. Effective for rate years beginning on or after January 1, 2020, threshold property payment interim adjustments for a facility reimbursed under the Fair Rental Value payment system in section 16.136 G, may receive a property payment rate interim adjustment for threshold projects the cumulative cost of which during the three years between physical appraisals is between the following threshold project cost limits: the lesser of $316,816 or $10,000 per bed in service; and the greater of $1,620,943 or $20,000 per bed in service.

(1) The commissioner shall update these threshold project cost limits each January 1 by the annual percent change in the construction cost per square foot value based on the information that is publicly available on November 1 immediately preceding the rate year.

(2) A facility seeking a property payment rate interim adjustment must request an adjustment after the threshold project is completed. The nursing facility or the lease

holder must have incurred the threshold project cost subsequent to the facility's last physical appraisal.

(3) Effective January 1 or July 1, whichever occurs first after a facility completes a threshold project and requests the property payment rate interim adjustment, the commissioner shall add the allowable reported threshold project costs to the facility's URC under section 16.136 and to the DRC under section 16.136 before calculating an adjusted property payment rate. The commissioner shall not include in the facility's limited URC threshold project costs reported to the commissioner between physical appraisals that exceed the maximum cumulative project cost limits.

(4) In subsequent property payment rate calculations following the completion of a physical appraisal, the commissioner shall eliminate any interim adjustment to the DRC and URC.

(5) At the option of the commissioner, the commissioner may adjust the appraisal schedule for a nursing facility that has completed a threshold project.

(6) If more or less than three years pass between a facility's physical appraisals, the commissioner shall prorate the facility's threshold project cost limits accordingly.

(7) After the initial rate year project adjustments are allowed once annually based on the previous project completion date.

(8) Two threshold projects may not be conducted at the same time. Purchases for a second project must be made after the completion date of the first project.

L. For rate years beginning on or after January 1, 2020, the interim payment rates and settle-up payment rates for a newly constructed nursing facility, or a nursing facility with an increase in licensed capacity of 50 percent or more shall be established as follows:

(1) The effective date of the interim payment rates is the date the nursing facility is certified for the medical assistance program. The nursing facility must continue to receive the interim payment rates until the settle-up payment rates are determined.

(2) For the 15-month period following the settle-up reporting period, the settle-up payment rates must be determined according to (1).

(3) The settle-up payment rates are effective retroactively to the beginning of the interim payment rates and are effective until the end of the interim rate period.

(4) Interim payment rates will be based upon the following:

(a) the anticipated interim costs and anticipated interim resident days reported on the interim cost report, and, the anticipated interim standardized days must be used for the interim;

(b) the anticipated interim costs and anticipated interim standardized days will be used in determining the allowable historical direct care cost per standardized day;

(c) the anticipated interim costs and anticipated interim resident days will be used in determining the allowable historical other care-related cost per resident day;

(d) the anticipated interim costs and anticipated interim resident days will be used to determine the allowable historical external fixed costs per day;

(e) the total care-related payment rate limits established in effect at the beginning of the interim period must be increased by ten percent; and

(f) the other operating payment rate is based on the metro median facility that is in effect for the rate year must be used for the other operating cost per day.

M. Determination of settle-up payment rates. When the interim payment rates begin between May 1 and September 30, the nursing facility shall file settle-up cost reports for the period from the beginning of the interim payment rates through September 30 of the following year. When the interim payment rates begin between October 1 and April 30, the nursing facility shall file settle-up cost reports for the period from the beginning of the interim payment rates to the first September 30 following the beginning of the interim payment rates.

(1) For the 15-month period following the settle-up reporting period, the settle-up payment rates must be determined according to section 16.140 M.

(2) The settle-up payment rates are effective retroactively to the beginning of the interim payment rates and are effective until the end of the interim rate period.

(3) Settle-up payment rates are determined according to the following:

(g) the allowable costs and resident days reported on the settle-up cost report and the standardized days must be used for the interim and settle-up period;

(h) the allowable costs and standardized days will be used to determine the allowable historical direct care cost per standardized day;

(i) the allowable costs and the allowable resident days will be used to determine both the allowable historical other care-related cost per resident day;

(j) the allowable costs and the allowable resident days will be used to determine the allowable historical external fixed costs per day;

(k) the total care-related payment limits established in section 23.100 are the limits for the settle-up reporting periods. If the interim period includes more than one July 1 date, the commissioner shall use the total care-related payment rate limit increased by ten percent for the second July 1 date; and

(l) the other operating payment rate is based on the metro median facility that is in effect for the rate year must be used for the other operating cost per day.

SECTION 17.000 PAYMENT FOR REAL ESTATE TAXES AND SPECIAL ASSESSMENTS

The total real estate taxes and actual special assessments and payments permitted under Section 5.000, item CC must be divided by actual resident days to compute the payment rate for real estate taxes and special assessments. Special assessments are reimbursed as paid by the facility except that facilities that incur special sewer assessments as part of their utility bill may reclassify that amount to the real estate tax and special assessment cost category. Real estate taxes are reimbursed based on the real estate tax assessed for the calendar year following the reporting year and are adjusted to account for the difference between the tax year and the reporting year in which the taxes are due. This adjustment is equivalent to ½ the increase or decrease in the property tax liability of a facility. The Commissioner shall include the reported actual or payments in lieu of real estate taxes of each nursing facility as an operating cost of that nursing facility. Allowable costs under this subdivision for payments made by a nonprofit nursing facility that are in lieu of real estate taxes shall not exceed the amount that a nursing facility would have paid to a city or township and county for fire, police, sanitation an road maintenance costs had real estate taxes been levied on that property for those purposes.

Special assessment costs specifically for pre-approved clean energy-related property projects will be time-limited rate adjustments awarded through a competitive application process. These special assessment payments are computed by dividing the allowable project costs by actual resident days and are included in the external fixed rate in section 23.140.

SECTION 17.010 **Payment for long term care consultation fees.** Until September 30, 2013, the estimated annual cost of screenings for each nursing facility are included as an allowable operating cost for reimbursement purposes. The estimated annual costs reported are divided by the facility's actual resident days for the cost report period. The resulting per diem amount is included in the calculation of the total payment rate under Section 18.000. However, these costs are not included in the calculation of either the care related or other operating cost limits, nor are they indexed to account for anticipated inflation.

SECTION 17.020 **Payment for increase in Department of Health license fees.** A nursing facility’s case mix payment rates include an adjustment to include the cost of any increase in Minnesota Department of Health licensing fees for the facility taking effect on or after July 1, 2001.

SECTION 18.000 COMPUTATION OF TOTAL PAYMENT RATE

SECTION 18.010 **Total payment rate.** The total payment rate is the sum of the operating cost payment rate (including any efficiency incentive calculated under Sections 11.030 and 11.040, and the preadmission screening cost per diem calculated under Section 17.010), the property-related payment rate, and the real estate tax and special assessments payment rate. The total payment rate becomes effective on July 1 of the rate year following the reporting year.

For projects approved on or after March 1, 2020, a new nursing facility created under the state's competitive moratorium application process, the total payment rate must be determined according to Section 16.140, L.

SECTION 18.020 **Private payment rate limitation.** The total payment rate must not exceed the rate paid by private paying residents for similar services for the same period. The private payment rate limitation shall not apply to retroactive adjustments to the total payment rate unless the total payment rate being adjusted was subject to the private payment rate limitation.

SECTION 18.030 **Private room payment rate.** A private room payment rate of 115 percent of the established total payment rate for a resident must be allowed if the resident is a medical assistance recipient and the private room is considered as a medical necessity for the resident or others who are affected by the resident's condition except as in Section 16.110, item C. Effective October 1, 2009, the private room payment rate is 111.5 percent of the total payment rate. Conditions requiring a private room must be determined by the resident's attending physician and submitted to the department for approval or denial by the Department on the basis of medical necessity.

For a nursing facility with a total property payment rate determined under the Fair Rental Value system in section 16.136, G, the amount paid for a private room is 111.5 percent of the established total payment rate for a resident if the resident is a medical assistance recipient and the private room is considered a medical necessity for the resident or others who are affected by the resident's condition.

SECTION 18.040 **Adjustment of total payment rate.** If the Department finds nonallowable costs, errors, or omissions in the nursing facility's historical costs, the nursing facility's affected total payment rates must be adjusted. If the adjustment results in an underpayment to the nursing facility, the Department shall pay to the nursing facility the underpayment amount within 120 days of written notification to the nursing facility. If the adjustment results in an overpayment to the nursing facility, the nursing facility shall pay to the Department the entire overpayment within 120 days of receiving the written notification from the Department. Interest charges must be assessed on underpayment or overpayment balances outstanding after 120 days written notification of the total payment rate determination.

If an appeal has been filed under Section 19.000, any payments owed by the nursing facility or by the Department must be made within 120 days of written notification to the nursing facility of the Department's ruling on the appeal. Interest charges must be assessed on balances outstanding after 120 days of written notification of the Department's ruling on the appeal. The annual interest rate charged must be the rate charged by the Commissioner of the department of revenue for late payment of taxes, which is in effect on the 121st day after the written notification.

SECTION 19.000 APPEAL PROCEDURES

SECTION 19.010 **Scope**. A provider may appeal from a determination of a payment rate established pursuant to this attachment and reimbursement rules of the Department if the appeal, if successful, would result in a change to the provider's payment rate or to the calculation of maximum charges to therapy vendors under Section 22.130. Appeals must be filed in accordance with procedures in this section.

SECTION 19.020 **Filing an appeal.** To appeal, the provider will file with the Department a written notice of appeal; the appeal must be postmarked or received by the Commissioner within 60 days of the date of publication printed on the notice updating payment rates. The notice of appeal must specify each disputed item; the reason for the dispute; the total dollar amount in dispute for each separate disallowance, allocation, or adjustment of each cost item or part of a cost item; the computation that the provider believes is correct; the authority in statute or rule upon which the provider relies for each disputed item; the name and address of the person or firm with whom contacts may be made regarding the appeal; and other information required by the Commissioner.

SECTION 19.030 **Contested case procedures appeals review process.** Effective August 1, 1997, the following apply.

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

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

by the parties to the contested case.

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

D. A contested case hearing must be heard by an administrative law judge. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the determination of a payment rate is incorrect.

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

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

G. Effective August 1, 1997, the Commissioner may use the procedures described in this section to resolve appeals filed before July 1,1997.

SECTION 19.040 **Attorney's fees and costs.**

A. For an issue appealed under Section 19.010, the prevailing party in a contested case proceeding or, if appealed, in subsequent judicial review, must be awarded reasonable attorney's fees and costs incurred in litigating the appeal, if the prevailing party shows that the position of the opposing party was not substantially justified. The procedures for awarding fees and costs set forth in state law regarding procedures for award of fees in contested cases must be followed in determining the prevailing party's fees and costs except as otherwise provided in this section. For purposes of this section, "costs" means subpoena fees and mileage, transcript costs, court reporter fees, witness fees, postage and delivery costs, photocopying and printing costs, amounts charged the Commissioner by the office of administrative hearings, and direct administrative costs of the Department; and "substantially justified" means that a position had a reasonable basis in law and fact, based on the totality of the circumstances prior to and during the contested case proceeding and subsequent review.

B. When an award is made to the Department under this section, attorney fees must be

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

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

of the issue, the complexity, of the issue, and other factors deemed appropriate by the administrative law judge.

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

E. Attorney fees and costs awarded to the Department for proceedings under this section must not be reported or treated as allowable costs on the provider's cost report.

F. Fees and costs awarded to a provider for proceedings under this section must be reimbursed to them within 120 days of the final decision on the award of attorney fees and costs.

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

H. Amounts collected by the Commissioner pursuant to this section must he deemed to be recoveries.

I. This section applies to all contested case proceedings set on for hearing by the Commissioner on or after April 29, 1988, regardless of the date the appeal was filed.

SECTION 19.050 **Legal and related expenses.** Legal and related expenses for unresolved challenges to decisions by governmental agencies shall be separately identified and explained on the

provider's cost report for each year in which the expenses are incurred. When the challenge is resolved in favor of the governmental agency, the provider shall notify the Department of the extent to which its challenge was unsuccessful or the cost report filed for the reporting year in which the challenge was resolved. In addition the provider shall inform the Department of the years in which it claimed legal and related expenses and the amount of the expenses claimed in each year relating to the unsuccessful challenge. The Department shall reduce the provider's medical assistance rate in the subsequent rate year by the total amount claimed by the provider for legal and related expenses incurred in an unsuccessful challenge to a decision by a governmental agency.

SECTION 20.000 SPECIAL EXCEPTIONS TO THE PAYMENT RATE

Section 20.010 **Swing beds.** Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed unless:

A. The facility in which the swing bed is located is eligible as a sole community provider, as defined in 42 CFR §412.92.

B. As of January 1, 2004, the facility in which the swing bed is located had an agreement with the Department to provide medical assistance swing bed services. This exception applies to swing bed services provided on or after July 1, 2005.

C. The facility is a public hospital owned by a governmental entity with 15 or fewer licensed acute-care beds.

D. Nursing facility care has been recommended for the person by a long-term care consultation team.

E. The person no longer requires acute-care services.

F. No nursing facility beds are available within 25 miles of the facility.

G. Medical assistance also covers up to ten days of nursing care provided to a patient in a swing bed if: (1) the patient's physician certifies that the patient has a terminal illness or condition that is likely to result in death within 30 days and that moving the patient would not be in the best interest of the patient and patient's family; (2) no open nursing home beds are available within 25 miles of the facility; and (3) no open beds are available in any Medicare hospice program within 50 miles of the facility.

The daily medical assistance payment rate for nursing care for a person in a swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually on July 1 of each year.

SECTION 20.020 **Negotiated rates for services for ventilator-dependent persons.** A nursing facility may receive a negotiated payment rate to provide services to a ventilator-dependent person if:

A. Nursing facility care has been recommended for the person by a long-term care consultation team.

B. The person has been hospitalized and no longer requires inpatient acute care hospital services.

C. Necessary services for the person cannot be provided under existing nursing facility rates.

A negotiated adjustment to the operating cost payment rate for a nursing facility must reflect only the additional cost of meeting the specialized care needs of a ventilator-dependent person based on documentation of supplies used and time spent on caring for the resident, up to the maximum rate described below. For persons who are initially admitted to a nursing facility before July 1, 2001, and have their payment rate negotiated after July 1, 2001, the negotiated payment rate must not exceed 200 percent of the highest RUGs rate. For persons initially admitted to a facility on or after July 1, 2001, the negotiated payment rate must not exceed 300 percent of the highest RUGs rate. The adjustment may be negotiated with a resident who is ventilator-dependent, for that resident.

Effective July 1, 2007, or upon opening a unit of at least ten beds dedicated to care of ventilator-dependent persons, whichever is later, the operating payment rates for residents meeting the ventilator-dependent criteria above in A-C, in a nursing facility in Waseca county that on February 1, 2007, was licensed for 70 beds and reimbursed under Sections 1.000 to 22.000 or pursuant to Section 22.000, shall be 300 percent of the facility’s highest RUG rate.

SECTION 20.025 **Special payment rates for short-stay nursing facilities.** For the rate year beginning on or after July 1, 1993, a nursing facility whose average length of stay for the preceding reporting years is (1) less than 180 days; or (2) less than 225 days in a nursing facility with more than 315 licensed beds must be reimbursed for allowable costs up to 125 percent of the total care-related limit and 105 percent of the other-operating-cost limit for hospital-attached nursing facilities. A nursing facility that received the benefit of this limit during the rate year beginning July 1, 1992, continues to receive this rate during the rate year beginning July 1, 1993 even if the nursing facility's length of stay is more than 180 days in the rate years subsequent to the rate year beginning July 1, 1991. For purposes of this section a nursing facility shall compute its average length of stay by dividing the nursing facility's actual resident days for the reporting year by the nursing facility's total resident discharges for that reporting year.

SECTION 20.026 **Interim closure payments for nursing facilities designated for closure under**

an approved closure plan and special rate adjustments for nursing facilities remaining open under an approved closure plan. Instead of payments pursuant to Sections 1.000 to 21.000 or pursuant to the prospective rate-setting methodology in Section 22.000, the Department may approve a closure plan or a phased plan, permitting certain nursing facilities to receive interim closure payments or special rate adjustments.

A. For the purposes of this section, the following have the meanings given.

(1) "Closure plan" means a system to close one or more nursing facilities and reallocate the resulting savings to provide special rate adjustments at other nursing facilities. A closure plan may be submitted by nursing facilities that are owned or operated by a nonprofit corporation owning or operating more than 22 nursing facilities. Approval of a closure plan expires 18 months after approval, unless commencement of closure has occurred at all nursing facilities designated for closure under the plan.

(2) "Commencement of closure" means the date the Department of Health is notified of a planned closure, as part of an approved closure plan.

(3) "Completion of closure" means the date the final resident of a facility designated for closure in a closure plan is discharged, or the date on which beds from a partial closure are delicensed and decertified.

(4) "Interim closure payments" means the medical assistance payments that may be made to a nursing facility designated for closure in an approved closure plan.

(5) "Phased plan" means a closure plan affecting more than one nursing facility undergoing closure that is commenced and completed in phases.

(6) "Special rate adjustment" means an increase in a nursing facility's operating rates. The special rate adjustment for each facility will be allocated proportionately to the various rate per diems included in that facility's operating rate.

B. The Department will not approve a closure plan or a phased plan unless it determines that projected state savings equal or exceed projected state and county government costs, including facility costs during the closure period, the estimated costs of special rate adjustments, estimated resident relocation costs, the cost of services to relocated residents, and state agency administrative costs relative to the plan. To achieve cost neutrality, costs may only be offset against savings that occur within the same state fiscal year. For purposes of a phased plan, the requirement that costs must not exceed savings applies to both the aggregate costs and savings of the plan and to each phase of the plan.

C. Interim closure payments. To pay interim closure payments, the Department will:

(1) Apply the interim and settle-up rate provisions of Section 12.000 to include facilities covered under this section, effective from commencement of closure to completion of closure;

(2) Notwithstanding Section 16.140, item B, extend the length of the interim period, but no longer than 12 months;

(3) Limit the amount of payable expenses related to the acquisition of new capital assets;

(4) Prohibit the acquisition of additional capital debt or refinancing of existing capital debt unless prior approval is obtained from the Department;

(5) Establish as the aggregate administrative operating cost limitation for the interim period the actual aggregate administrative operating costs for the period immediately before commencement of closure that is of the same duration as the interim period;

(6) Require the retention of financial and statistical records until it has audited the interim period and the settle-up rate;

(7) Make aggregate payments under this section for the interim period up to the level of the aggregate payments for the period immediately before to commencement of closure that is of the same duration as the interim period; and

(8) Change any other provision to which all parties to the plan agree.

D. As part of a phased plan, a nursing facility may receive a special rate adjustment The special rate adjustment may be received under more than one phase of the closure plan, and the cost savings from the closure of the nursing facility designated for closure may be applied as an offset to the subsequent costs of more than one phase of the plan. If a facility is proposed to receive a special rate adjustment or provide cost savings under more than one phase of the plan, the proposal must describe the special rate adjustments or cost savings in each phase of the plan.

(1) The special rate adjustment is effective no earlier than the first day of the month following completion of closure of all nursing facilities designated for closure under the closure plan.

(2) For purposes of a phased plan, the special rate adjustment for each phase is effective no earlier than the first day of the month following completion of closure of all nursing

facilities designated for closure in that phase of the plan.

SECTION 20.027 **Planned closure rate adjustments under an approved closure plan.** Between August 1, 2001, and June 30, 2003, the Department may approve planned closures of up to 5,140 nursing facility beds, less the number of beds delicensed in facilities during the same period without approved closure plans or that have notified the Minnesota Department of Health of their intent to close without an approved closure plan. Beginning July 1, 2004, the Department may negotiate planned closures only if the proposals are budget neutral to the state.

A. For the purposes of this section, the following have the meanings given.

(1) "Closure" means the cessation of operations of a facility and delicensure and decertification of all beds within the facility.

(2) "Closure plan" means a plan to close a facility and reallocate a portion of the resulting savings to provide planned closure rate adjustments at other facilities. A closure plan is submitted to the Department by a facility. Approval of a closure plan expires 18 months after approval, unless commencement of closure has begun.

(3) "Commencement of closure" means the date on which residents and designated representatives are notified of a planned closure as part of an approved closure plan.

(4) "Completion of closure" means the date on which the final resident of a facility designated for closure in an approved closure plan is discharged, or the date on which beds from a partial closure are delicensed and decertified.

(5) "Partial closure" means the delicensure and decertification of a portion of the beds within the facility.

B. Closure rate adjustment calculation. The Department will calculate the planned closure rate adjustment according to the following:

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080 for planned closure rate adjustments negotiated or effective before March 1, 2006. Beginning March 1, 2006, the amount available is the net reduction of nursing facility beds mulitiplied by a negotiated closure rate adjustment factor. For planned closures approved after June 30, 2009, a per-bed amount of $2,080 is allowed for a nursing facility planned bed closure and the rate negotiation process is eliminated. Between November 1, 2011, and June 30, 2013, applications will not be accepted for planned closure rate adjustments.

(2) the total number of beds in the facility or facilities receiving the planned

closure rate adjustment are identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

C. A planned closure rate adjustment is effective on the first day of the month following completion of closure of a facility designated for closure in the application and becomes part of the facility's external fixed payment rate. Effective for closures occurring after August 1, 2017, a planned closure rate adjustment is effective on the first day of January or July, whichever occurs first, following the day on which closure of the facility is completed.

D. A facility or facilities paid pursuant to this Attachment with a closure plan may assign a closure rate adjustment to another facility or facilities that are not closing or, in the case of partial closure, to the facility undertaking the partial closure. A facility may also elect to have a closure rate adjustment shared equally by the five nursing facilities with the lowest total operating payment rates in the state development region in which the facility that is closing is located.

Facilities that delicense beds without a closure plan, or whose closure plan is not approved by the Department, may assign a planned closure rate adjustment (including assigning the amount calculated under item B to themselves) if:

(1) they are delicensing no more than five beds, or less than six percent of their total licensed bed capacity, whichever is greater;

(2) are located in a county in the top three quartiles of beds per 1,000 persons aged 65 or older; and

(3) have not delicensed beds in the prior three months.

If a facility delicenses six or more beds, or six percent or more of its total licensed bed capacity, whichever is greater, and does not have an approved closure plan or is not eligible for the adjustment calculated in item B, the Department calculates the amount the facility would have been eligible to assign and uses this amount to provide equal rate adjustments to the five nursing facilities with the lowest total operating payment rates in the state development region in which the facility that delicensed beds is located.

E. Reserved

F. A facility receiving a planned closure rate adjustment is eligible for any other rate adjustments under this Attachment.

G. A facility that receives a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment is computed according to item B.

H. If the per bed dollar amount specified in item B, subitem (1) is increased, the Department will recalculate planned closure rate adjustments for facilities that delicense beds to reflect the increase in the per bed dollar amount. The recalculated planned closure rate adjustment is effective from the date the per bed dollar amount is increased. The removal of the limit in item B, subitem (1) does not constitute an increase.

I. Upon the request of a facility that is completely ceasing operations, the Department may increase the total payment rates of that facility by 50%. This rate increase is to reimburse relocation costs or other costs related to facility closure, may be in effect for up to 60 days, and cannot begin until the number of residents in the closing facility is less than or equal to 90% of its licensed capacity.

J. After a facility that elected a 50 % rate increase under paragraph I has ceased operations, the Department will delay the implementation of a closure rate adjustment computed under paragraphs A. to H. to recover the Medicaid-related costs of the rate increase given under paragraph I.

K. A planned closure rate adjustment shall be approved for an eight-bed facility in Big Stone County for reassignment to a 50-bed facility within the county.

SECTION 20.030 **Facility serving exclusively the physically handicapped.** Nursing facilities that serve physically handicapped individuals and which have an average length of stay of less than one year are limited to 140% of the other-operating-cost limit for hospital attached nursing facilities. Other facilities serving physically handicapped individuals but whose average length of stay is not less than one year have a limit of 105 percent of the appropriate hospital attached limit.

SECTION 20.035 **Hospital-attached nursing facilities.** A hospital-attached nursing facility shall use the same cost allocation principles and methods used in the reports filed for the Medicare program.

A hospital-attached nursing facility is a facility which meets the criteria in items A, B, or C.

A. A nursing facility recognized by the Medicare Program to be a hospital-based nursing facility for purposes of being subject to higher cost limits accorded hospital-attached nursing

facilities under the Medicare Program is a hospital-attached nursing facility.

B. A nursing facility which, prior to June 30, 1983, was classified as a hospital-attached nursing facility under Minnesota Rules, and which has applied for hospital-based nursing facility status under the Medicare program during the reporting year or the nine-month period following the nursing facility's reporting year, is considered a hospital-attached nursing facility for the rate year following the reporting year or the nine-month period in which the facility made its Medicare application.

(1) The nursing facility must file its cost report or an amended cost report for that reporting year before the following rate year using Medicare principles and Medicare's recommended cost allocation methods had the Medicare Program's hospital-based nursing facility status been granted to the nursing facility.

(2) If the nursing facility is denied hospital-based nursing facility status under the Medicare Program, the nursing facility's payment rates for the rate years the nursing facility was considered to be a hospital-attached nursing facility pursuant to this paragraph shall be recalculated treating the nursing facility as a non-hospital-attached nursing facility.

C. The surviving nursing facility of a nonprofit or community operated hospital-attached nursing facility which suspended operation of the hospital is considered, at the option of the facility, a hospital-attached nursing facility for five subsequent rate years. In the fourth year the facility will receive 60 percent of the difference between the hospital-attached limit and the freestanding nursing facility limit, and in the fifth year the facility will receive 30 percent of the difference.

D. For rate years beginning on or after July 1, 1995, a nursing facility is considered a hospital-attached nursing facility for purposes of setting payment rates under this attachment if it meets the above requirements, and: (1) the hospital and nursing facility are physically attached or connected by a tunnel or skyway; or (2) the nursing facility was recognized by the Medicare Program as hospital attached as of January 1, 1995 and this status has been maintained continuously.

SECTION 20.040 **Receivership.**

A. The Department in consultation with the Department of Health may establish a receivership fee that exceeds a nursing facility payment rate when the Commissioner of Health or the Commissioner of Human Services determines a nursing facility is subject to the receivership provisions. In establishing the receivership fee payment, the Commissioner must reduce the receiver's requested receivership fee by amounts that the Commissioner determines are included in the nursing facility's payment rate and that can be used to cover part or all of the receivership fee. Amounts that can be used to reduce the receivership fee shall be determined by reallocating facility staff or costs that were formerly paid by the nursing facility before the receivership and are no longer required to be paid. The amounts may include any efficiency incentive, allowance, and other

amounts not specifically required to be paid for expenditures of the nursing facility. If the receivership fee cannot be covered by amounts in the nursing facility's payment rate, a receivership fee payment shall be set according to subitems (1) and (2) and payment shall be according to subitems (3) through (5).

(1) The receivership fee per diem is determined by dividing the annual receivership fee by the nursing facility's resident days from the most recent cost report for which the Department has established a payment rate or the estimated resident days in the projected receivership fee period.

(2) The receivership fee per diem shall be added to the nursing facility's payment rate.

(3) Notification of the payment rate increase must meet the requirements for the notice to private paying residents.

(4) The payment rate in item C for a nursing facility shall be effective the first day of the month following the receiver's compliance with the notice conditions.

(5) The Department may elect to make a lump sum payment of a portion of the receivership fee to the receiver or managing agent. In this case, the Department and the receiver or the managing agent shall agree to a repayment plan.

B. Upon receiving a recommendation from the Commissioner of Health for a review of rates, the Commissioner shall grant an adjustment to the nursing facility's payment rate. The Commissioner shall review the recommendation of the Commissioner of Health, together with the nursing facility's cost report to determine whether or not the deficiency or need can be corrected or met by reallocating nursing facility staff, costs, revenues, or other resources including any investments, efficiency incentives, or allowances. If the Commissioner determines that the deficiency cannot be corrected or the need cannot be met, the Commissioner shall determine the payment rate adjustment by dividing the additional annual costs established during the Commissioner's review by the nursing facility's
actual resident days from the most recent desk-audited cost report.

C. If the Department has established a receivership fee per diem for a nursing facility in receivership under item A or a payment rate adjustment under item B, the Department must deduct these receivership payments according to subitems (1) to (3).

(1) The total receivership fee payments shall be the receivership per diem plus the payment rate adjustment multiplied by the number of resident days for the period of the receivership. If actual resident days for the receivership period are not made available within two weeks of the Department's written request, the Department shall compute the resident days by prorating the

facility's resident days based on the number of calendar days from each portion of the nursing facility's reporting years covered by the receivership period.

(2) The amount determined in item A must be divided by the nursing facility's resident days for the reporting year in which the receivership period ends.

(3) The per diem amount in item B shall be subtracted from the nursing facility's operating cost payment rate for the rate year following the reporting year in which the receivership period ends. This provision applies whether or not there is a sale or transfer of the nursing facility, unless the provision of item G apply.

D. The Commissioner of Health may request the Commissioner to reestablish the receivership fee payment when the original terms of the receivership fee payment have significantly changed with regard to the cost or duration of the receivership agreement. The Commissioner, in consultation with the Commissioner of Health, may reestablish the receivership fee payment when the Commissioner determines the cost or duration of the receivership agreement has significantly changed. The provisions of developing a receivership fee payment apply to the reestablishment process.

E. The Commissioner of Health shall recommend to the Commissioner a review of the rates for a nursing home or boarding care home that participates in the Medical Assistance Program that is in voluntary or involuntary receivership, and that has needs or deficiencies documented by the Department of Health. If the Commissioner of Health determines that a review of the rate is needed, the Commissioner shall provide the Commissioner of Human Services with: (1) a copy of the order or determination that cites the deficiency or need; and (2) the Commissioner's recommendation for additional staff and additional annual hours by type or employee and additional consultants, services, supplies, equipment, or repairs necessary to satisfy the need or deficiency.

F. Downsizing and Closing nursing facilities. If the nursing facility is subject to a downsizing to closure process during the period of receivership, the Commissioner may reestablish the nursing facility's payment rate. The payment rate shall be established based on the nursing facility's budgeted operating costs, the receivership property related costs, and the management fee costs for the receivership period divided by the facility's estimated resident days for the same period. The Commissioner of Health and the Commissioner shall make every effort to first facilitate the transfer of private paying residents to alternate service sites prior to the effective date of the payment rate. The cost limits and the case mix provisions in the rate setting system shall not apply during the portion of the receivership period over which the nursing facility downsizes to closure.

G. Sale or transfer of a nursing facility in receivership after closure.

(1) Upon the subsequent sale or transfer of a nursing facility in receivership, the

Commissioner must recover any amounts paid through payment rate adjustments under item F which exceed the normal cost of operating the nursing facility. Examples of costs in excess of the normal cost of operating the nursing facility include the managing agent's fee, directly identifiable costs of the managing agent, bonuses paid to employees for their continued employment during the downsizing to closure of the nursing facility, prereceivership expenditures paid by the receiver, additional professional services such as accountants, psychologists, and dietitians, and other similar costs incurred by the receiver to complete receivership. The buyer or transferee shall repay this amount to the Commissioner within 60 days after the Commissioner notifies the buyer or transferee of the obligation to repay. The buyer or transferee must also repay the private-pay resident the amount the private-pay resident paid through payment rate adjustment.

(2) If a nursing facility with payment rates subject to item F, subitem (1) is later sold while the nursing facility is in receivership, the payment rates in effect prior to the receivership shall be the new owner's payment rates. Those payment rates shall continue to be in effect until the rate year following the reporting period ending on September 30 for the new owner. The reporting period shall, whenever possible, be at least five consecutive months. If the reporting period is less than five months but more than three months, the nursing facility's resident days for the last two months of the reporting period must be annualized over the reporting period for the purpose of computing the payment rate for the rate year following the reporting period.

Upon the subsequent sale or transfer of the nursing facility, the department may recover amounts paid through payment rate adjustments under this section. The buyer or transferee will repay this amount to the department within 60 days after the department notifies the buyer or transferee of the obligation to repay. The buyer or transferee must also repay the private-pay resident the amount the private-pay

resident paid through payment rate adjustment.

SECTION 20.050 **Medicare upper payment limit rate adjustment.** In the event that the aggregate payment rates determined under this plan exceed the Medicare upper payment limit established at 42 CFR § 447.272, a rate adjustment will be determined as follows:

A. Aggregate the payment rates determined under this plan.

B. Determine the Medicare upper payment limit in accordance with 42 CFR §447.272.

C. Subtract item A from item B.

D. If item C exceeds zero, divide the amount in item C by total statewide nursing facility resident days during the rate year in which item C exceeds zero.

E. Subtract item D from the rate otherwise determined under this plan.

SECTION 20.060 **Employee scholarship costs and training in English as a second language (ESL).**

A. For the rate years beginning July 1, 2001 and July 1, 2002, the Department will provide to each nursing facility reimbursed pursuant to Sections 1.000 to 21.000 or pursuant to Section 22.000 a scholarship per diem of $.25 to the total operating payment rate to be used for employee scholarships and to provide job-related training in ESL.

B. For rate years beginning on or after July 1, 2003, the $.25 scholarship per diem is removed from the total operating payment rate, and the scholarship per diem is based on actual costs. In calculating the per diem, only costs related to tuition and direct educational expenses are permitted.

C. Effective July 1, 2015, nursing facilities that close beds may request a recalculation of their scholarship rate for the remainder of the rate year to reflect the reduction in resident days, when the resulting rate adjustment is $.15 per day or greater.

D. Effective October 1,2015 through December 31, 2017, a scholarship per diem of up to $.25 will be added to the payment rate for each nursing facility without a scholarship per diem included within their rate and now requests this increase.

SECTION 20.070 **Alternative to Phase-in of Rebasing for Publicly-Owned Nursing Facilities**

(a) For services delivered beginning October 1, 2011, nursing facilities whose physical plant is owned by a city, county, or hospital district may enter into an agreement with the Department for a higher payment rate under this section. Until December 31, 2015, nursing facilities that apply shall be eligible to select an operating payment rate, for a RUG's level with a weight of 1.00, up to the rate calculated in section 23.150 without application of the phase-in under section 23.160. The rates for the other RUG's levels shall be computed as provided under section 23.150.

(b) For services delivered between October 1, 2011, and December 31, 2015, rates determined under this section shall be based on the most recent available cost report.

(c) Beginning January 1, 2016, nursing facilities whose physical plant is owned by a city, county, or hospital district may select an operating payment rate, for a RUG's level with a weight of 1.00, up to the amount allowable under the Medicare upper payment limit. The rates for the other RUG's levels shall be computed as provided under section 23,150.

(d) The commissioner may, at any time, reduce the payments under this section based on the commissioner's determination that the payments shall cause nursing facility rates to exceed the state's Medicare upper payment limit or any other federal limitation. If the commissioner determines a reduction is necessary, the commissioner shall reduce all payment rates for participating nursing facilities by a percentage applied to the amount of increase they would otherwise receive under this section and shall notify participating facilities of the reductions. The percentage would be calculated by dividing the amount over the upper payment limit by the total Medicaid payments for the participating facilities.

SECTION 20.090 **Disaster-related provisions.**

A. Notwithstanding a provision to the contrary, a facility may receive payments for expenses specifically incurred due to a disaster. Payments will be based on actual documented costs for the period during which the costs were incurred, and will be paid as an add-on to the facility's payment rate, or as a lump sum payment. The actual costs paid will be reported on the next annual cost report as non-allowable costs, in order to avoid duplicate payment. Costs submitted for payments will be subject to review and approval by the Department. The Department's decision is final and not subject to appeal. Costs not paid in this manner may be claims on the subsequent cost report for inclusion in the facility's payment rate.

B. For transfers of less than 60 days, the rates continue to apply for evacuated facilities and residents are not counted as admissions to facilities that admit them. The resident days related to the placement of such residents who continued to be billed under an evacuated facility's provider number are not counted in the cost report submitted to calculate rates, and the additional expenditures are considered non-allowable costs for facilities that admit victims.

C. For transfers of 60 days or more, a formal discharge/admission process must be completed, so that the resident becomes a resident of the receiving facility.

D. When a person is admitted to a facility from the community, the resident assessment requirement in Section 15.010 is waived. If the resident has resided in the facility for 60 days or more, the facility must comply with Section 15.010 as soon as possible.

SECTION 20.100 **Bed layaway and delicensure.**

A. For rate years beginning on or after July 1, 2000, a nursing facility reimbursed under Sections 1.000 through 21.000 that places beds on layaway will, for purposes of application of the downsizing incentive in Section 16.040, item G, and calculation of the rental per diem, have the beds given the same effect as if the beds had been delicensed so long as they remain on layaway. At the time of a layaway, a facility may change its single bed election for use in calculating capacity days

under Section 16.110. The property payment rate increase is effective the first day of January or July, whichever occurs first, following the date on which the layaway of the beds becomes effective under state law.

B. For rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary in Section 22.000, a nursing facility reimbursed under Section 22.000 that places beds on layaway is, for so long as the beds remain on layaway, allowed to:

(1) Aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system in Section 22.000;

(2) Retain or change the facility's single bed election for use in calculating capacity days under Section 16.110; and

(3) Establish capacity days based on the number of beds immediately prior to the layaway and the number of beds after the layaway.

C. The Department will increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the layaway of beds and subitems (1), (2), and (3). If a facility reimbursed under Section 22.000 completes a moratorium exception project after its base year, the base year property rate is the moratorium project property rate. The base year rate is inflated by the factors in Section 22.060, items C through F. The property payment rate increase is effective the first day of the month following the month in which the layaway of the beds becomes effective.

D. If a nursing facility removes a bed from layaway status in accordance with state law, the Department will establish capacity days based on the number of licensed and certified beds in the facility not on layaway and will reduce the nursing facility's property payment rate in accordance with item B.

E. For the rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under Section 22.000, a nursing facility reimbursed under that section, with delicensed beds after July 1, 2000, by giving notice of the delicensure to the Department of Health according to the notice requirements in state law, is allowed to:

(1) Aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) Retain or change the facility's single bed election for use in calculating capacity days under Section 16.110; and

(3) Establish capacity days based on the number of beds immediately prior to the delicensure and the number of beds after the delicensure.

The Department will increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the delicensure of beds and subitems (1), (2), and (3). If a facility reimbursed under Section 22.000 completes a moratorium exception project after its base year, the base year property rate is the moratorium project property rate. The base year rate is inflated by the factors in Section 22.060, items C through F. The property payment rate increase is effective the first day of the month following the month in which the delicensure of the beds becomes effective.

F. For nursing facilities reimbursed pursuant to Sections 1.000 to 21.000 or Section 22.000, any beds placed on layaway are not included in calculating facility occupancy as it pertains to leave days.

G. For nursing facilities reimbursed pursuant to Sections 1.000 to 21.000 or Section 22.000, the rental rate calculated after placing beds on layaway may not be less than the rental rate prior to placing beds on layaway.

H. A nursing facility receiving a rate adjustment as a result of this section must not increase nursing facility rates for private pay residents until it notifies the residents, or the persons responsible for payment of the increase, in writing 30 days before the increase takes effect. No notice is required if a rate increase reflects a necessary change in a resident’s level of care.

I. A facility that does not utilize the space made available as a result of bed layaway or delicensure under this section to reduce the number of beds per room or provide more common space for nursing facility uses or perform other activities related to the operation of the nursing facility shall have its property rate increase calculated under this section reduced by the ratio of the square footage made available that is not used for these purposes to the total square footage made available as a result of bed layaway or delicensure.

J. Effective July 1, 2013, the minimum time a nursing facility must keep a bed in layaway is shortened from one year to six months; and the minimum time that a facility must wait to put a bed in layaway after having removed a bed from layaway is shortened from one year to six months.

Section 20.110. **Indian Health Service and Tribal 638 Facilities.** Effective July 6, 2011, per diem payments to facilities of the Indian Health Service and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title I or title V of the Indian Self-Determination and Education Assistance Act, PL 93-638, shall be equal to the Medicaid outpatient per visit rate published annually by the Director of the Indian Health Service under the authority of sections 321(a) and 322(b) of the Public health Service Act (42 U.S.C.

248 and 249(b)), Public Law 83-568 (42 U.S.C. 2001(a)) and the Indian Health Care Improvement Act (25 U.S.C 1601 *et seq*.))

SECTION 20.115. **Consolidation of nursing facilities effective September 1, 2011**.
A. The commissioner of health, in consultation with the commissioner of human services, may approve a request for consolidation of nursing facilities that includes the closure of one or more facilities and the upgrading of the physical plant of the remaining nursing facility or facilities, the costs of which exceed the threshold project limit under section 16.1374, item F. In the event the commissioners approve the request, the commissioner of human services shall calculate an adjustment to the payment rate for external fixed costs according to clauses (1) to (3):
(1) the closure of beds shall not be eligible for a planned closure rate adjustment under section 20.027;
(2) the construction project permitted in this clause shall not be eligible for a threshold project or a moratorium exception rate adjustment under section 22.061; and
(3) the remaining facility or facilities' payment rate for external fixed costs shall be increased by an amount equal to 65 percent of the projected net cost savings to the state calculated in paragraph (b), divided by the state's medical assistance percentage of medical assistance dollars, and then divided by estimated medical assistance resident days, as determined in paragraph (c), of the remaining nursing facility or facilities in the request in this paragraph. For construction upgrades completed after August 1, 2013, the rate adjustment is effective on the later of the first day of the month following completion of the construction upgrades in the consolidation plan or the first day of the month following the complete closure of a facility designated for closure in the consolidation plan. If more than one facility is receiving upgrades in the consolidation plan, each facility's date of construction completion must be evaluated separately. For construction upgrades completed after August 1, 2017, any rate adjustment resulting from the upgrade will be implemented on the first of the month of January or July, whichever occurs first, after both the completion of the construction upgrades in the consolidation plan and the complete closure of the facility or facilities designated for closure in the consolidation plan.

B. For purposes of calculating the net cost savings to the state, the commissioner shall consider clauses (1) to (7):
(1) the annual savings from estimated medical assistance payments from the net number of beds closed taking into consideration only beds that are in active service on the date of the request and that have been in active service for at least three years;
(2) the estimated annual cost of increased case load of individuals receiving services under the elderly waiver;
(3) the estimated annual cost of elderly waiver recipients receiving support under group residential housing;
(4) the estimated annual cost of increased case load of individuals receiving services under the alternative care program;
(5) the annual loss of license surcharge payments on closed beds;

(6) the savings from not paying planned closure rate adjustments that the facilities would otherwise be eligible for under section 20.027; and
(7) the savings from not paying adjustments to the payment rate for external fixed costs from submission of renovation costs that would otherwise be eligible as threshold projects under section 22.061.

C. For purposes of the calculation in paragraph A., clause (3), the estimated medical assistance resident days of the remaining facility or facilities shall be computed assuming 95 percent occupancy multiplied by the historical percentage of medical assistance resident days of the remaining facility or facilities, as reported on the facility's or facilities' most rec ent nursing facility statistical and cost report filed before the plan of closure is submitted, multiplied by 365.

D. For purposes of net cost of savings to the state in paragraph B., the average occupancy percentages will be those reported on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, and the average payment rates shall be calculated based on the approved payment rates in effect at the time the consolidation request is submitted.

E. For projects approved on or after March 1, 2020, the 65 percent projected net cost savings to the state calculated in A (3) must be applied to the moratorium cost of the project and the remainder must be added to the available funding for the state's moratorium exception process.

F. Consolidation project applications not approved by the commissioner prior to March 1, 2020, are subject to the state's moratorium process.

SECTION 20.120. **Method for determining budget-neutral nursing facility rates for relocated beds effective September 1, 2011.**

A. Nursing facility rates for bed relocations must be calculated ~~by comparing the estimated medical assistance costs prior to and after the proposed bed relocation using the calculations in this subdivision. All payment rates are based on a 1.0 case mix level, with other case mix rates determined accordingly.~~ for the facility receiving the beds in accordance with section 23.150. No part of the source facility rates are transferred to the receiving facility. Nursing facility beds on layaway status that are being moved must be included in the calculation for both the originating and receiving facility and treated as though they were in active status with the occupancy characteristics of the active beds of the originating facility. Bed relocation threshold projects seeking reimbursement for costs that exceed the moratorium limit or that result in a newly constructed or newly licensed building must apply to relocate beds as part of the state's competitive moratorium application process.

B. Medical assistance costs of the beds in the originating nursing facilities must be calculated as follows:
(1) multiply each originating facility's total payment rate for a RUGS weight of 1.0 by the facility's percentage of medical assistance days on its most recent available cost report;
(2) take the products in clause (1) and multiply by each facility's average case mix score for medical assistance residents on its most recent available cost report;
(3) take the products in clause (2) and multiply by the number of beds being relocated, times 365; and
(4) calculate the sum of the amounts determined in clause (3).

C. Medical assistance costs in the receiving facility, prior to the bed relocation, must be calculated as follows:
(1) multiply the facility's total payment rate for a RUGS weight of 1.0 by the medical assistance days on the most recent cost report; and
(2) multiply the product in clause (1) by the average case mix weight of medical assistance residents on the most recent cost report.

D. The commissioner shall determine the medical assistance costs prior to the bed relocation which must be the sum of the amounts determined in paragraphs B and C.

E. The commissioner shall estimate the medical assistance costs after the bed relocation as follows:
(1) estimate the medical assistance days in the receiving facility after the bed relocation. The commissioner may use the current medical assistance portion, or if data does not exist, may use the statewide average, or may use the provider's estimate of the medical assistance utilization of the relocated beds;
(2) estimate the average case mix weight of medical assistance residents in the receiving facility after the bed relocation. The commissioner may use current average case mix weight or, if data does not exist, may use the statewide average, or may use the provider's estimate of the average case mix weight; and
(3) multiply the amount determined in clause (1) by the amount determined in clause (2) by the total payment rate for a RUGS weight of 1.0 that is the highest rate of the facilities from which the relocated beds either originate or to which they are being relocated so long as that rate is associated with ten percent or more of the total number of beds to be in the receiving facility after the bed relocation.

F. If the amount determined in paragraph E is less than or equal to the amount determined in paragraph C, the commissioner shall allow a total payment rate equal to the amount used in paragraph E, clause (3).

G. If the amount determined in paragraph E is greater than the amount determined in paragraph D, the commissioner shall allow a rate with a RUGS weight of 1.0 that when used in paragraph E, clause (3), results in the amount determined in paragraph D being equal to the amount determined in paragraph D.

H. If the commissioner relies upon provider estimates in paragraph E, clause (1) or (2), then annually, for three years after the rates determined in this subdivision take effect, the commissioner shall determine the accuracy of the alternative factors of medical assistance case load and RUGS weight used in this subdivision and shall reduce the total payment rate for a RUGS weight of 1.0 if the factors used result in medical assistance costs exceeding the amount in paragraph D. If the actual medical assistance costs exceed the estimates by more than five percent, the commissioner shall also recover the difference between the estimated costs in paragraph E and the actual costs. The commissioner may require submission of data from the receiving facility needed to implement this paragraph.

SECTION 20.130 **Medicare certification**

Effective July 1, 2012, Medicaid certified nursing facilities are not required to participate in the Medicare program. Nursing facility providers that do not participate in or accept Medicare assignment must refer and document the referral of dual eligible recipients for whom placement is requested and for whom the resident would be qualified for a Medicare-covered stay to Medicare providers. The commissioner of human services shall audit nursing facilities that do not accept Medicare and determine if dual eligible individuals with Medicare qualifying stays have been admitted. If such a determination is made, the commissioner shall deny Medicaid payment for the first 20 days of that resident's stay.

SECTION 21.000 ANCILLARY SERVICES

SECTION 21.010 **Setting payment and monitoring use of therapy services.**
At the option of the nursing facility, payment for ancillary materials and services otherwise covered under the plan may be made to either the nursing facility in the operating cost per diem, to the vendor of ancillary services, or to the nursing facility outside of the operating cost per diem. Effective August 1, 2009, at the option of the nursing facility, payment for ancillary materials and services

otherwise covered under the plan may be made only to either the vendor of ancillary services or to the nursing facility outside of the operating cost per diem. The avoidance of double payments shall be made through audits and adjustments to the nursing facility's annual cost report. The Department will also determine if the materials and services are cost effective and as would be incurred by a prudent and cost-conscious buyer. Therapy services provided to a recipient must be medically necessary and appropriate to the medical condition of the recipient. If the vendor, nursing facility, or ordering physician cannot provide adequate medical necessity justification, the Department may recover or disallow the payment for the services and may require prior authorization for therapy services or may impose administrative sanctions to limit the provider participation in the medical assistance program.

SECTION 21.020 **Certification that treatment is appropriate.** The therapist who provides or supervises the provision of therapy services must certify in writing that the therapy's nature, scope, duration, and intensity are appropriate to the medical condition of the recipient every 30 days. The Department shall utilize a peer review program to make recommendations regarding the medical necessity of services provided.

SECTION 22.000 CONTRACTUAL ALTERNATIVE PAYMENT RATES AFTER AUGUST 1, 1995

SECTION 22.010 **Contractual alternative payment rate.** A nursing facility may apply to be paid a contractual alternative payment rate instead of the cost-based payment rate established under Sections 1.000 to 21.000. A nursing facility selected to receive an alternative payment rate must enter into a contract with the state. Payment rates and procedures for facilities selected to receive an alternative payment rate are determined and governed by this section and by the terms of the contract. Different contract terms for different nursing facilities may be negotiated.

SECTION 22.020 **Requests for proposals.**

A. At least twice annually the Department will publish a request for proposals to provide nursing facility services according to this section. All proposals must be responded to in a timely manner.

B. Any proposal may be rejected if, in the judgment of the Department, a contract with a particular facility is not in the best interests of the residents of the facility or the state of Minnesota.

SECTION 22.030 **Proposal requirements.**

A. In issuing the request for proposals, the Department may develop reasonable requirements which, in the judgment of the Department, are necessary to protect residents or ensure that the contractual alternative payment demonstration project furthers the interest of the state of Minnesota.

B. The request for proposals may include, but need not be limited to, the following:

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

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

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

(4) A requirement to agree to participate in a project to develop data collection systems and outcome-based standards for managed care contracting for long-term care services;

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

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

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

SECTION 22.040 **Selection process.**

A. The number of proposals that can be adequately supported with available state resources, as determined by the Department, may be accepted.

B. The Department may accept proposals from a single nursing facility or from a group of facilities through a managing entity.

C. The Department will seek to ensure that nursing facilities under contract are located in all geographic areas of the state.

D. In addition to the information and assurances contained in the submitted proposals, the Department may consider the following in determining whether to accept or deny a proposal:

(1) The facility's history of compliance with federal and state laws and rules, except that a facility deemed by the Department to be in substantial compliance with federal and state laws

and rules is eligible to respond to a request for proposal. A facility's compliance history is not the sole determining factor in situations where the facility has been sold and the new owners have submitted a proposal;

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

(3) The facility's financial history and solvency; and

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

E. If the Department rejects the proposal of a nursing facility, it will provide written notice to the facility of the reason for the rejection, including the factors and evidence upon which the rejection was based.

SECTION 22.050 **Duration and termination of contracts.**

A. ~~Contracts with nursing facilities may be executed beginning November 1, 1995.~~

B. All contracts entered into under this section are for a term not to exceed four years.

C. Either party may terminate a contract at any time without cause by providing 90 calendar days advance written notice to the other party. The decision to terminate a contract is not appealable.

D. The contract will be renegotiated for additional terms of up to four years, unless either party provides written notice of termination. The provisions of the contract will be renegotiated at a minimum of every four years by the parties before the expiration date of the contract.

E. The parties may voluntarily renegotiate the terms of the contract at any time by mutual agreement.

F. If a nursing facility fails to comply with the terms of a contract, the Department will provide reasonable notice regarding the breach of contract and a reasonable opportunity for the facility to come into compliance.

G. If the facility fails to come into compliance or to remain in compliance, the Department may terminate the contract. ~~If a contract is terminated, the contract payment remains in effect for the remainder of the rate year in which the contract was terminated, but in all other respects the provisions of this section do not apply to that facility effective as of the date the contract is~~

~~terminated.~~

H. ~~The contract must contain a provision governing the transition back to the cost-based reimbursement system established under Sections 1.000 to 21.000.~~

SECTION 22.060 **Alternate rates for nursing facilities.**

For nursing facilities that have their payment rates determined pursuant to this section rather than pursuant to Sections 1.000 to 21.000, a rate must be established under this section as follows:

A. The nursing facility must enter into a written contract with the Department;

B. A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the same payment rate as established for the facility under Sections 1.000 to 21.000;

C. A nursing facility's property payment rate~~s~~ for the second and subsequent years of a facility's contract under this section are the previous rate year's property payment rate~~s~~ plus an inflation adjustment as provided in items D and E

D. 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) as forecasted by the Department in the fourth quarter of the calendar year preceding the rate year.

E. 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.

SECTION 22.061 **Construction project rate adjustments**.

A. Effective October 1, 2006, facilities paid under this section may receive a property rate adjustment for construction projects that exceed the threshold for additions and replacements described in section 16.1373, but are below the threshold described in section 16.1374, item F.

(1) For these projects, capital assets purchased shall be counted as construction project costs for a rate adjustment request made by a facility if they are purchased within 24 months of the completion of the construction project, purchased after the completion date of any prior construction project, and are not purchased prior to July 14, 2005.

(2) Except as otherwise provided in this section, the definitions, rate calculation methods, and principles in Section 16.000 shall be used to calculate rate adjustments for

allowable construction projects of facilities under this section and the moratorium exceptions process.

(3) Facilities completing construction projects between October 1, 2005, and October 1, 2006, are eligible to have a property rate adjustment effective October 1, 2006. Facilities completing projects after October 1, 2006, are eligible for a property rate adjustment effective on the first day of the month following the completion date.

4) Facilities shall be allowed construction project rate adjustments no sooner than 12 months after completing a previous construction project. Facilities must request the rate adjustment by submitting the request plus related supported documentation to the Department within 60 days after the project's completion date. Effective August 1, 2009, if a nursing facility gives notice more than 60 days after completion of a construction project, the rate adjustment is effective on the first of the month following the notice. If the notice is given within 60 days of completion, the rate adjustment is effective on the first of the month following the completion of the project. For construction projects completed after January 1, 2018, any rate adjustment resulting from the completed project will be implemented on the first of the month of January or July, whichever occurs first, after both the project's completion and the submission of the provider's request for an adjustment.

(5) Capacity days shall be computed according to Section 16.110. For rate calculations under this section, the number of licensed beds in the nursing facility shall be the number existing after the construction project is completed and the number of days in the nursing facility's reporting period shall be 365.

B. The value of assets to be recognized for a total replacement project shall be computed as follows:

(1) Replacement-cost-new limits under Section 16.1374, and the number of beds allowed under Section 16.040, item G, shall be used to compute the maximum amount of assets allowable in a facility's property rate calculation.

(2) If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved under a moratorium exception, the assets to be used in the rate calculation cannot exceed the lesser of the amount determined under Section 16.1374, item G, or the actual allowable costs of the construction project.

(3) A current request that is not the result of a project under a moratorium exception cannot exceed the limit under Section 16.1374, item G.

(4) Applicable credits must be deducted from the cost of the construction project.

C. The value of assets to be recognized for all other projects shall be computed as follows:

(1) Replacement-cost-new limits under Section 16.1374, and the number of beds allowed under Section 16.040, item G shall be used to compute the maximum amount of assets allowable in a facility's property rate calculation.

(2) The value of a facility's assets to be compared to the amount in item (1) begins with the total appraised value from the last rate notice a facility received when its rates were set under Sections 1.000 through 21.000. This value shall be indexed by the factor in Section 16.040 for each rate year the facility received an inflation factor on its property-related rate when its rates were set under this section. The value of assets listed as previous capital additions, capital additions, and special projects on the facility's base year rate notice and the value of assets related to a construction project for which the facility received a rate adjustment when its rates were determined under this section shall be added to the indexed appraised value.

(3) The maximum amount of assets to be recognized in computing a facility's rate adjustment after a project is completed is the lesser of the aggregate replacement-cost-new limit computed in subitem (1) minus the assets recognized in subitem (2) or the actual allowable costs of the construction project.

(4) If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved as an exception to the state’s moratorium, the assets to be added to the rate calculation cannot exceed the lesser of the amount determined under Section 16.1374, item G or the actual allowable costs of the construction project plus amendments approved by the Minnesota Department of Health. A current request that is not the result of a project under a moratorium exception cannot exceed the limit stated in section 16.1374, item G. Assets disposed of as a result of a construction project and applicable credits must be deducted from the cost of the construction project.

D. For construction projects approved under a moratorium exception, allowable debt may never exceed the lesser of the cost of the assets purchased, the threshold limit in Section 16.1374, item G, or the replacement-cost-new limit less previously existing capital debt.

E. For construction projects that were not approved under a moratorium exception, allowable debt is limited to the lesser of the threshold in Section 16.1374, item G, or the applicable limit in items B or C, less previously existing capital debt. Amounts of debt taken out that exceed the costs of a construction project shall not be allowed regardless of the use of the funds. For all

construction projects being recognized, interest expense and average debt shall be computed based on the first 12 months following project completion. "Previously existing capital debt" means capital debt recognized on the last rate determined under Sections 1.000 through 21.000, and the amount of debt recognized for a construction project for which the facility received a rate adjustment when its rates were determined under this section. For a total replacement project as defined in section 16.1374, item H, the value of previously existing capital debt shall be zero.

F. In addition to the interest expense allowed from the application of item D, the amounts allowed under Section 16.1374, item B will be added to interest expense.

G. The equity portion of the construction project shall be computed as the allowable assets in item B or C, less the average debt in item D and F. The equity portion must be multiplied by 5.66 percent and the allowable interest expense in item D must be added. This sum must be divided by 95 percent of capacity days to compute the construction project rate adjustment.

H. For projects that are not a total replacement of a nursing facility, the amount in item G is adjusted for nonreimbursable areas and then added to the current property payment rate of the facility.

I. For projects that are a total replacement of a nursing facility, the amount in item G becomes the new property payment rate after being adjusted for nonreimbursable areas. Any amounts existing in a facility's rate before the effective date of the construction project for equity incentives under Section 16.1373, capital repairs and replacements under Section 16.1372, or refinancing incentives under Section 16.1376, shall be removed from the facility's rates.

J. No additional equipment allowance is allowed under Section 16.100, as the result of construction projects under this section. Allowable equipment shall be included in the construction project costs.

K. Capital assets purchased after the completion date of a construction project shall be counted as construction project costs for any future rate adjustment request made by a facility under Section 16.1374, item G, if they are purchased within 24 months of the completion of the future construction project.

L. In subsequent rate years, the property payment rate for a facility that results from the application of this subdivision shall be the amount inflated in Section 22.060, item F.

M. Construction projects are eligible for an equity incentive under Section 16.1373. When computing the equity incentive for a construction project under this section, only the allowable costs and allowable debt related to the construction project shall be used. The equity incentive shall not be a part of the property payment rate and not inflated under Section 22.060, item F. Effective

October 1, 2006, all equity incentives for nursing facilities reimbursed under this section shall be allowed for a duration determined under Section 16.1373, item C.

SECTION 22.065 **Facility rate increases beginning July 1, 1999.** For the rate year beginning July 1, 1999, a nursing facility's case mix rate is divided into the following components: compensation operating rate, non-compensation operating rate, property rate and other-components rate. The compensation and non-compensation operating rates are increased by the percentages in Section 11.049, item B, subitem (1), respectively. The property related payment rate is increased as described in Section 22.060, item F. The other-components rate is not increased from the June 30, 1999 rate.

A. A nursing facility in Becker county licensed for 102 beds on September 30, 1998 receives the following increases:

(1) $1.30 in its case mix class A payment rate;

(2) $1.33 in its case mix class B payment rate;

(3) $1.36 in its case mix class C payment rate;

(4) $1.39 in its case mix class D payment rate:

(5) $1.42 in its case mix class E and F payment rate;

(6) $1.45 in its case mix class G payment rate;

(7) $1.49 in its case mix class H payment rate;

(8) $1.51 in its case mix class I payment rate;

(9) $1.54 in its case mix class J payment rate; and

(10) $1.59 in its case mix class K payment rate;

B. A nursing facility in Chisago county licensed for 101 beds on September 30, 1998 receives an increase of $3.67 in each case mix payment rate:

C. A nursing facility in Canby, licensed for 75 beds will have its property-related per diem rate increased by $1.21. This increase will be recognized in the facility's contract payment rate under this section.

D. A nursing facility in Golden Valley with all its beds licensed to provide residential rehabilitative services to physically handicapped young adults has the payment rate computed according to this section increased by $14.83; and

E. A county-owned 130-bed nursing facility in Park Rapids has its per diem contract payment rate increased by $1.02 for costs related to compliance with comparable worth requirements.

SECTION 22.066 **Facility rate increases beginning July 1, 2000.** For the rate year beginning July 1, 2000, nursing facilities with an average operating rate as described in items A through F receive the rate increases indicated. "Average operating rate" means the average of the eleven (A-K) case mix operating rates. The increases are added following the determination under Section 11.050 of the payment rate for the rate year beginning July 1, 2000, and will be included in the nursing facilities' total payment rates for the purposes of determining future rates under this attachment to the State plan.

A. Nursing facilities with an average operating rate of $110.769 receive an operating cost per diem increase of 5.9 percent, provided that the facilities delicense, decertify, or place on layaway status, if that status is otherwise permitted by law, 70 beds.

B. Nursing facilities with an average operating rate of $79.107 receive an increase of $1.54 in each case mix payment rate.

C. Nursing facilities with an average operating rate of $80.267 receive an increase in their case mix resident class A payment of $3.78, and an increase in their payment rate for all other case mix classes of that amount multiplied by the class weight for that case mix class established in Section 13.030.

D. Nursing facilities with an average operating rate of $94.987 receive an increase of $2.03 in each case mix payment rate to be used for employee wage and benefit enhancements.

E. Nursing facilities with an average operating rate of $82.369 have their operating cost per diem increased by the following amounts:

(1) case mix class A, $1.16;

(2) case mix class B, $1.50;

(3) case mix class C, $1.89;

(4) case mix class D, $2.26;

(5) case mix class E, $2.63;

(6) case mix class F, $2.65;

(7) case mix class G, $2.96;

(8) case mix class H, $3.55;

(9) case mix class I, $3.76;

(10) case mix class J, $4.08; and

(11) case mix class K, $4.76.

F. Nursing facilities with an average operating rate of $95.974 that decertified 22 beds in calendar year 1999 have their property-related per diem payment rate increased by $1.59.

SECTION 22.067 **Facility rate increases beginning July 1, 2001.**

A. For the rate year beginning July 1, 2001, the Department will provide an adjustment equal to 3.0 percent of the total operating payment rate. The operating payment rates in effect on June 30, 2001 include the adjustment in Section 11.070.

B. For rate years beginning on or after July 1, 2001 and for admissions occurring on or after July 1, 2001, the total payment rate for the first 90 paid days after admission is:

(1) for the first 30 paid days, the rate is 120 percent of the facility's medical assistance rate for each case mix class; and

(2) for the next 60 paid days after the first 30 paid days, the rate is 110 percent of the facility's medical assistance rate for each case mix class.

C. For rate years beginning on or after July 1, 2001 and for admissions occurring on or after July 1, 2001, beginning with the 91st paid day after admission, the payment rate is the rate otherwise determined under this Section.

D. Payments under item B apply to admissions occurring on or after July 1, 2001, and before July 1, 2003, and to resident days occurring before July 30, 2003.

E. For the rate year beginning July 1, 2001, the Department will adjust the operating

payment rates for low-rate facilities. For each case mix level, if the amount computed under item A is less than the amount of the operating payment rate target level for July 1, 2001, below, the Department will make available the lesser of the amount of the operating payment rate target level for July 1, 2001, or an increase of ten percent over the rate in effect on June 30, 2001, as an adjustment to the operating payment rate. For the purposes of this item, facilities are considered metro if they are located in Anoka, Carver, Dakota, Hennepin, Olmsted, Ramsey, Scott, or Washington counties; or in the cities of Moorhead or Breckenridge; or in St. Louis county, north of Toivola and south of Cook; or in Itasca county, east of a north south line two miles west of Grand Rapids.

Operating Payment Rate Target Level for July 1, 2001

Case Mix Classification	Metro	Nonmetro
A	$76.00	$68.13
B	$83.40	$74.46
C	$91.67	$81.63
D	$99.51	$88.04
E	$107.46	$94.87
F	$107.96	$95.29
G	$114.67	$100.98
H	$126.99	$111.31
I	$131.34	$115.06
J	$138.34	$120.85
K	$152.26	$133.10

F. For the rate year beginning July 1, 2001, two-thirds of the money resulting from the rate adjustment under item A and one-half of the money resulting from the rate adjustment under items B through D must be used to increase the wages and benefits and pay associated costs of all employees except management fees, the administrator, and central office staff.

(1) Money received by a facility resulting from the rate adjustments under items A through D must be used only for wage and benefit increases implemented on or after July 1, 2001.

(2) A facility may apply for the portions of the rate adjustments under this item. The application must be made to the Department and contain a plan by which the facility will distribute the funds to its employees. For a facility 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, if the agreement is finalized after June 30, 2001.

(a) The Department will review the plan to ensure that the rate adjustments are used

as required in this item.

(b) To be eligible, a facility must submit its plan for the wage and benefit distribution by December 31, 2001. If a facility's plan for wage and benefit distribution is effective for its employees after July 1, 2001, the portion of the rate adjustments are effective the same date as its plan.

(3) A hospital-attached facility may include costs in its distribution plan for wages and benefits and associated costs of employees in that organization's shared services departments, provided that the facility and the hospital share common ownership and adjustments for hospital services using the diagnostic-related grouping payment rates per admission under Medicare are less than three percent during the 12 months before July 1, 2001. If a hospital-attached facility meets these qualifications, the difference between the rate adjustments approved for nursing facility services and the rate increase approved for hospital services may be permitted as a distribution in the hospital-
attached facility's plan regardless of whether the use of the funds is shown as being attributable to employee hours worked in the facility or employee hours worked in the hospital.

G. Notwithstanding Sections 1.020 and 18.020, upon the request of a facility, the Department may authorize the facility to raise per diem rates for private-pay residents on July 1 by the amount anticipated to be required upon implementation of the rate adjustments allowable under items A through D. Until the rate is finalized, the Department will require any amounts collected, which must be used as provided in this item, to be placed in an escrow account established for this purpose with a financial institution that provides deposit insurance. The Department shall conduct audits as necessary to ensure that:

(1) the amounts collected are retained in escrow until rates are increased to reflect the wage-related adjustment; and

(2) any amounts collected from private-pay residents in excess of the final rate are repaid to the private-pay residents with interest.

H. For rate years beginning on or after July 1, 2001, in calculating a facility's operating cost per diem for the purposes of constructing an array, determining a median, or otherwise performing a statistical measure of facility payment rates to be used to determine future rate increases, the Department will exclude adjustments for raw food costs under Section 8.020, item B, that are related to providing special diets based on religious beliefs.

I. For the rate year beginning July 1, 2001, facilities that changed their bed licensure from board and care beds to nursing home beds must have the additional cost of surcharge included in their rate. The increase is added following the determination of the payment rate for the rate year

beginning July 1, 2001, and is included in the facility's total payment rates for the purposes of determining future rates.

J. For the rate year beginning July 1, 2001, non-profit facilities in the county with the fewest beds per 1000 for age 65 and over that are not accepting beds from another closing non-profit facility receive a total increase of $10 in each case mix rate, as a result of increases provided under this item and item D. The increases under this item are added before the determination under item D, of the payment rate for the July 1, 2001 rate year, and are included in the facility's total payment ate for purposes of determining future rates through June 30, 2004.

SECTION 22.068 **Facility rate increases beginning January 1, 2002.**

For the rate period from January 1, 2002 through June 30, 2002, facilities that went from non-profit to for-profit status in 2000 receive an increase of $2.54 in each case mix payment rate to offset property tax payments due as a result of the facility's conversion from nonprofit to for-profit status. The increase will be added following the determination of the payment rate for the rate year beginning July 1, 2001, and will be included in a facility's total payment rates for the purposes of determining future rates.

SECTION 22.069 **Facility rate increases beginning July 1, 2002.**

A. For the rate year beginning July 1, 2002, the Department will provide an adjustment equal to 3.0 percent of the total operating payment rate. The operating payment rates in effect on June 30, 2001 include the adjustment in Section 11.070.

B. For the rate year beginning July 1, 2002, the Department will adjust the operating payment rates for low-rate facilities. For each case mix level, if the amount computed under items A is less than the amount of the operating payment rate target level for July 1, 2002, below, the Department will make available the lesser of the operating payment rate target level for July 1, 2002, or an increase of ten percent over the rate in effect on June 30, 2002, as an adjustment to the operating payment rate. For the purposes of this item, facilities are considered metro if they meet the requirements in Section 22.067, item D.

Operating Payment Rate Target Level for July 1, 2002

Case Mix Classification	Metro	Nonmetro
A	$78.28	$70.51
B	$85.91	$77.16
C	$94.42	$84.62
D	$102.50	$91.42
E	$110.68	$98.40

F	$111.20	$98.84
G	$118.11	$104.77
H	$130.80	$115.64
I	$135.38	$119.50
J	$142.49	$125.38
K	$156.85	$137.77

C. For the rate year beginning July 1, 2002, two-thirds of the money resulting from the rate adjustment under item A, and one-half of the money resulting from the rate adjustment under Section 22.067, items B and C and item B of this Section, must be used to increase the wages and benefits and pay associated costs of all employees except management fees, the administrator, and central office staff.

(1) Money received by a facility resulting from the rate adjustments under item A, Section 22.067, items B and C and item B of this Section must be used only for wage and benefit increases implemented on or after July 1, 2002.

(2) A facility may apply for the portions of the rate adjustments under this item. The application must be made to the Department and contain a plan by which the facility will distribute the funds to its employees. For a facility 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, if the agreement is finalized after the date of enactment of all increases for the rate year.

(a) The Department will review the plan to ensure that the rate adjustments are used as required in this item.

(b) To be eligible, a facility must submit its plan for the wage and benefit distribution by December 31, 2002. If a facility's plan for wage and benefit distribution is effective for its employees after July 1, 2002, the portion of the rate adjustments are effective the same date as its plan.

(3) A hospital-attached facility may include costs in its distribution plan for wages and benefits and associated costs of employees in that organization's shared services departments, provided that the facility and the hospital share common ownership and adjustments for hospital services using the diagnostic-related grouping payment rates per admission under Medicare are less than three percent during the 12 months before July 1, 2002. If a hospital-attached facility meets these qualifications, the difference between the rate adjustments approved for nursing facility services and the rate increase approved for hospital services may be permitted as a distribution in the hospital-attached facility's plan regardless of whether the use of the funds is shown as being

attributable to employee hours worked in the facility or employee hours worked in the hospital.

D. Notwithstanding Sections 1.020 and 18.020, upon the request of a facility, the Department may authorize the facility to raise per diem rates for private-pay residents on July 1 by the amount anticipated to be required upon implementation of the rate adjustments allowable under item A, Section 22.067, items B and C, and item B of this Section. Until the rate is finalized, the

Department will require any amounts collected, which must be used as provided in this item, to be placed in an escrow account established for this purpose with a financial institution that provides deposit insurance. The Department shall conduct audits as necessary to ensure that:

(1) the amounts collected are retained in escrow until rates are increased to reflect the wage-related adjustment; and

(2) any amounts collected from private-pay residents in excess of the final rate are repaid to the private-pay residents with interest.

E. Each facility paid pursuant to Section 22.000 receives an increase in each case mix payment rate of $1.25, which is added following the determination of the payment rate for the facility. This increase is not subject to any annual percentage increase.

SECTION 22.070 **Facility rate increases beginning June 1, 2003.**

Each facility paid pursuant to Section 22.000 receives an increase in each case mix payment rate of $5.56, which is added following the determination of the payment rate for the facility. This increase is not subject to any annual percentage increase. For facilities with board and care beds, the increase is equal to $5.56 multiplied by the ratio of the number of nursing home beds to the number of total beds.

SECTION 22.071 **Facility rate changes beginning July 1, 2003.**

A. For rate years beginning on or after July 1, 2003 and for admissions occurring on or after July 1, 2003, the total payment rate is:

(1) for the first 30 calendar days after admission, 120 percent of the facility's medical assistance rate for each RUG class; and

(2) beginning with the 31st calendar day after admission, the rate otherwise determined under Sections 1.000 through 21.000.

SECTION 22.072 **Facility rate changes beginning January 1, 2004.** Effective January 1, 2004, the

rates under Section 22.071 are not allowed if a resident has resided during the previous 30 calendar days in:

(1) the same facility;

(2) a facility owned or operated by a related party; or

(3) a facility or part of a facility that closed or, effective August 1, 2004, was in the process of closing.

SECTION 22.073 **Facility rate changes beginning July 1, 2005.**

A. Medical Assistance provides for an additional annual payment for: 1) State Fiscal Year 2006 (July 1, 2005 through June 30, 2006), which includes a Department payment made for that state fiscal year and distributed by a sponsoring institution prior to October 1, 2006; and 2) State Fiscal Year 2007 (July 1, 2006 through June 30, 2007), which includes a Department payment made for that state fiscal year and distributed by a sponsoring institution prior to October 1, 2007, to Medical Assistance-enrolled teaching nursing facilities. The Medical Assistance payment is increased according to the sum of items A through C:

(1) (Total amount available for this purpose in the Minnesota Medical Education and Research Trust Fund, minus $4,850,000, divided by the state matching rate), multiplied by .9, multiplied by .67, multiplied by [(the number of full-time equivalent trainees at the facility multiplied by the average cost per trainee for all sites) divided by (the total training costs across all sites)], for each type of graduate trainee at the clinical site.

(2) (Total amount available for this purpose in the Minnesota Medical Education and Research Trust Fund, minus $4,850,000, divided by the state matching rate), multiplied by .9, multiplied by .33, multiplied by the ratio of the facility's public program revenue to the public program revenue for all teaching sites.

(3) (A portion of the total amount available for this purpose in the Minnesota Medical Education and Research Trust Fund minus $4,850,000), divided by the state matching rate, multiplied by .10, multiplied by the provider's sponsoring institution's ratio of the amounts in subitems (1) and (2) to the total dollars available under subitems (1) and (2), in the amount the sponsoring institution determines is necessary to offset clinical costs at the facility.

In accordance with Code of Federal Regulations, title 42, section 447.253(b)(2), this payment will not exceed the Medicare upper limit payment and charge limits as specified in Code of Federal Regulations, title 4, section 447.272.

B. Pursuant to subitems (1) through (3), the operating payment rate for each facility is increased by 20 percent multiplied by the ratio of the number of new single-bed rooms created, divided by the number of active beds on July 1, 2005, for each bed closure resulting in the creation of a single-bed room after July 1, 2005.

(1) The Department may implement rate adjustments for up to 3,000 new single-bed rooms each fiscal year.

(2) For eligible bed closures for which the Department receives a notice from a facility during a calendar quarter that a bed has been delicensed and a new single-bed room been established, the rate adjustment is effective on the first day of the second month following that calendar quarter.

(3) A facility is prohibited from discharging residents for purposes of establishing single-bed rooms. A facility must submit documentation to the Department certifying the occupancy status of beds closed to create single-bed rooms.

SECTION 22.074 **Changes to nursing facility reimbursement beginning October 1, 2005.**

A. For the rate period beginning October 1, 2005, each facility receives an adjustment equal to 2.2553 percent of the total operating payment rate. The adjustment is distributed according to items B through D, below.

B. Except as provided in item C, 75% of the money resulting from the rate adjustment must be used to increase employee wages, benefits and associated costs and must be implemented on or after the effective date of the rate increase. “Employee” does not include management fees, the administrator, and central office staff.

C. A facility that incurred costs for employee wages, benefits and associated cost increases first provided after July 1, 2003 may count those costs toward the amount required to be spent on the items in item B. These costs must be reported to the Department.

D. A facility may apply for the 75% portion of the rate adjustment for employee wages, benefits and associated costs. The application must be made to the Department and contain a plan by which the facility will distribute the funds according to items B through C. For a facility 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, if the agreement is finalized after that date of enactment of all increases for the rate period and signed by both parties prior to submission to the Department.

SECTION 22.075 **Changes to nursing facility reimbursement beginning October 1, 2006.**

A. For the rate year beginning October 1, 2006, each receives an adjustment equal to 1.2553 percent of the total operating payment rate.

B. Seventy-five percent of the money resulting from the rate adjustment must be used to increase the Medicaid portion of wages and benefits and pay associated costs for all employees, except management fees, the administrator, and central office staff.

C. Seventy-five percent of the money received by the facility as a result of the adjustment must be used only for the Medicaid portion of wage, benefit, and staff increases implemented on or after the effective date of the rate increase and must not be used for increases implemented before that date.

D. A facility may apply for the rate adjustment for employee wages, benefits and associated costs. The application must be made to the Department and contain a plan by which the facility will distribute the funds according to items B and C. For a facility 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, if the agreement is finalized after that date of enactment of all increases for the rate period and signed by both parties prior to submission to the Department.

SECTION 22.076 **Quality score**

A. For purposes of the quality component of the total care-related limit at section 23.100, the commissioner shall determine a quality score for each nursing facility using the most recently available data as provided in the Minnesota Nursing Home Report Card. The quality score shall be determined as described below.

Beginning January 1, 2016, the quality score shall include up to 50 points related to the Minnesota quality indicators score, up to 40 points related to the resident quality of life score, and up to ten points related to the state inspection results score.

1. Nursing home MDS quality indicators (QIs) are derived from the Minimum Data Set (MDS) assessment instrument. The QIs measure quality mainly in clinical areas such as physical functioning, skin care, and pain. The 26 indicators are risk-adjusted, scored, and summed to form a composite facility QI score which can range from 0-40. The best 20% of the facilities for each QI in the state receive full points assigned to that QI, the poorest 15% of the facilities in the state for that QI receive no points. Points are distributed on a straight line relationship between those two thresholds.
2. Quality of life and resident satisfaction measures (QoL/RS) based on an annual in-person survey of a representative sample of residents (approximately 13,000). Domains measured in

the survey are satisfaction with care, mood, comfort, environmental adaptations, privacy, dignity, meaningful activity, food enjoyment, autonomy, individuality, security, and relationships. Proportions of positive responses in each domain are summed to form a total QoL/RS score which is risk-adjusted.

3. Minnesota Department of Health (MDH) Survey findings are scored with an algorithm developed by the Minnesota Department of Health. Facilities are scored from 0-10 according to findings of their most recent or prior MDH survey, confirmed complaints, and listing as a Special Focus provider. The facility score takes into account number of deficiencies, particularly those indicting actual harm, substandard quality of care, or immediate jeopardy.

B. **Quality improvement incentive system beginning October 1, 2015.**

For purposes of calculating the quality component of the payment rate for external fixed costs under section 23.140, the commissioner shall develop a quality improvement incentive program in consultation with stakeholders. The annual funding pool available for quality improvement incentive payments shall be equal to 0.8 percent of all operating payments, not including any rate components resulting from equitable cost-sharing for publicly owned nursing facility program participation under section 20.070, critical access nursing facility program participation under section 23.211, or performance-based incentive payment program participation under section 22.0761. For the period from October 1, 2015, to December 31, 2016, rate adjustments provided under this section shall be effective for 15 months. Beginning January 1, 2017, annual rate adjustments provided under this section shall be effective for one year, starting January 1 and ending the following December 31. This increase shall be included in the external fixed payment rate under section 23.140.

SECTION 22.0761 **Performance-incentive payments beginning July 1, 2007.**

A. Beginning July 1, 2007, nursing facilities may contract to earn negotiated performance-incentive Medicaid payments up to five percent above the facilities' operating payment rates for achieving contracted improvements in their quality of services. The Commissioner will accept qualified proposals from facilities submitted in response to an annual request for proposals that are designed to improve outcomes or achieve efficiencies through diverting or discharging residents to the community, adopting new technology to improve quality or efficiency, improve quality as measured by the Nursing Home Report Card or reduce acute care costs. Nursing facilities with existing contracts for the maximum 5% performance incentive payments for rate year October 1, 2009 are not eligible to apply. Criteria that will be used by the selection committee in reviewing the proposals include: the importance of the proposal; whether it is evidence-based; whether its goals are objective, measurable, reliable and prospective; whether it

is innovative and feasible; whether it has broad-based applicability; and whether any collaborative plan is clear.

The Department will enter into negotiations with those providers recommended by the selection committee. The total computable amount for state fiscal year 2009 is $6,714,000 plus federal financial participation. The total computable amount for state fiscal year 2010 and subsequent years is $6,042,600 plus federal financial participation. The incentive payments are time-limited rate adjustments paid for one to three years depending upon the project as approved for payment by the Commissioner. Payments are made in the usual manner in the monthly remittance advice as part of the daily per diem for Medicaid eligible nursing home residents.

B. Specified outcomes and related criteria shall consider:
(1) successful diversion or discharge of residents to the community;
(2) adoption of new technology to improve quality or efficiency;
(3) improved quality as measured by the Nursing Home Report Card;
(4) reduced acute care costs; and
(5) any additional outcomes proposed by a facility that the Commissioner of Human Services finds desirable.

SECTION 22.0762 **Changes to nursing facility reimbursement beginning October 1, 2007.**

A. Effective October 1, 2007, a nursing facility in Otter Tail County that was licensed for 57 beds as of December 31, 2004, shall receive an increase to the 60th percentile of the operating rates of all other Otter Tail County nursing facilities.

B. Effective October 1, 2007, a nursing facility in Martin County licensed for 93 beds as of January 1, 2006, shall receive an increase in the operating rate of $5 per resident day for all case mix classes.

C. For the rate year beginning October 1, 2007, each facility receives an operating payment rate adjustment equal to 1.87 percent of the operating payment rate in effect on September 30, 2007.

(1) Seventy-five percent of the money resulting from the rate adjustment must be used to increase the Medicaid portion of the compensation-related costs for employees directly employed by the facility on or after the effective date of the rate adjustment, except:

(a) the administrator;
(b) central office staff of a corporation that has an ownership interest in the facility or exercises control over the facility; or

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

(2) Two-thirds of the money available for compensation-related costs must be used for the Medicaid portion of wage increases for all employees directly employed by the facility on or after the effective date of the rate adjustment except those listed in clause 1(a) through (c).

(3) The wage adjustment that employees receive under paragraph (2) must be paid as an equal hourly percentage wage increase for all eligible employees. All wage increases 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 employes shall be allowed only for meeting the requirements in clause 1. This paragraph shall not apply to employees covered by a collective bargaining agreement.

(4) Compensation-related costs shall include all costs for:

(a) wages and salaries;
(b) FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;
(c) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions; and
(d) other benefits provided, subject to the approval of the commissioner.

(5) The portion of the rate adjustment under paragraph C that is not subject to the requirements in clauses 1 and 2 shall be provided to facilities effective October 1, 2007.

(6) Facilities may apply for the portion of the rate adjustment under paragraph C that is subject to the requirements in clauses 1 and 2. The application must be submitted to the commissioner within six months of the effective date of the rate adjustment, and the 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 clause under circumstances that are unusual and outside of the normal course of business operations. The application must contain:

(a) an estimate of the amounts of money that must be used as specified in

clauses (1) and (2);

(b) a detailed distribution plan specifying the allowable compensation-related and wage increases the facility will implement to use the funds available in paragraph (a);

(c) 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 (a), or posting a copy of the approved application, excluding the information required in clause (a), for a period of at least six weeks in an area of the nursing facility to which all eligible employees have access; and

(d) 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.

(7) The commissioner shall ensure that cost increases in distribution plans under paragraph (6), clause (b), that may be included in approved applications, comply with the following requirements:

(a) 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;

(b) a portion of the costs resulting from tenure-related wage or salary increases may be considered to be allowable wage increases, according to the following:
(i) determine the facility’s employee retention rate;
(ii) sum the median statewide average employee retention rate and one-half of the standard deviation of the statewide average employee retention rate;
(iii) if the amount in (i) is greater than the amount in (ii), the facility will be allowed to use in its distribution plan a percentage of anniversary increases equal the amount in

(i) multiplied by the difference between the amount in (I) and (ii).

(c) 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

(d) 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 enactment of this subdivision. 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.

(8) The commissioner shall review applications received under paragraph (6) and shall provide the portion of the rate adjustment under clauses (1) and (2) if the requirements of this item have been met. The rate adjustment shall be effective October 1. Notwithstanding paragraph C, 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.

D. 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 ended 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.

SECTION 22.0763 **Nursing facility rate increase beginning October 1, 2008.**

For the rate year beginning October 1, 2008, each facility receives an operating payment rate adjustment equal to 1.00 percent of the operating payment rate determined by the blending in Section 23.160.

(1) Seventy-five percent of the money resulting from the rate adjustment must be used to increase the Medicaid portion of the compensation-related costs for employees directly employed by the facility on or after the effective date of the rate adjustment, except:

(a) the administrator;
(b) central office staff of a corporation that has an ownership interest in the facility or exercises control over the facility; or
(c) persons paid by the facility under a management contract.

(2) Two-thirds of the money available for compensation-related costs must be used for the Medicaid portion of wage increases for all employees directly employed by the facility on or after the effective date of the rate adjustment except those listed in clause (1)(a) through (c).

(3) The wage adjustment that employees receive under paragraph (2) must be paid as an equal hourly percentage wage increase for all eligible employees. All wage increases 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 clause 1. This paragraph shall not apply to employees covered by a collective bargaining agreement.

(4) Compensation-related costs shall include all costs for:

(a) wages and salaries;
(b) FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;
(c) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions; and
(d) other benefits provided, subject to the approval of the commissioner.

(5) The portion of the rate adjustment under paragraph A that is not subject to the

requirements in clauses 1 and 2 shall be provided to facilities effective October 1, 2008.

(6) Facilities may apply for the portion of the rate adjustment under paragraph A that is subject to the requirements in clauses 1 and 2. The application must be submitted to the commissioner within six months of the effective date of the rate adjustment, and the 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 clause under circumstances that are unusual and outside of the normal course of business operations. The application must contain:

(a) an estimate of the amounts of money that must be used as specified in clauses (1) and (2);

(b) a detailed distribution plan specifying the allowable compensation-related and wage increases the facility will implement to use the funds available in paragraph (a);

(c) 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 (a), or posting a copy of the approved application, excluding the information required in clause (a), for a period of at least six weeks in an area of the nursing facility to which all eligible employees have access; and

(d) instructions for employees who believe they have not received the compensation-related or wage increases specified in paragraph (b), 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.

(7) The commissioner shall ensure that cost increases in distribution plans under paragraph (6), clause (b), that may be included in approved applications, comply with the following requirements:

(a) costs to be incurred during the applicable rate year resulting from wage and salary increases effective after October 1, 2007, and prior to the first day of the nursing facility's payroll period that includes

October 1, 2008, shall be allowed if they were not used in the prior year's application;

(b) a portion of the costs resulting from tenure-related wage or salary increases may be considered to be allowable wage increases, according to the following:

(i) determine the facility's employee retention rate;

(ii) sum the median statewide average employee retention rate and one-half of the standard deviation of the statewide average employee retention rate;

(iii) if the amount in (i) is greater than the amount in (ii), the facility will be allowed to use in its distribution plan a percentage of anniversary increases equal to the amount in (i) multiplied by the difference between the amount in (i) and (ii).

(c) 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, 2008, and prior to April 1, 2009; and

(d) 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 enactment of this subdivision. 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.

(8) The commissioner shall review applications received under paragraph (6) and shall provide the portion of the rate adjustment under clauses (1) and (2) if the requirements of this item 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.

22.0764. **Temporary nursing facility rate adjustment beginning October 1, 2008**

For the rate year beginning October 1, 2008, each facility receives a temporary operating payment rate adjustment equal to 1.00 percent of the operating payment rate determined by the blending in Section 23.160. This rate adjustment shall be removed from the facility's operating payment rate for the rate year beginning October 1, 2009.

Seventy-five percent of the money resulting from the rate adjustment must be used to provide the Medicaid portion of quarterly bonus payments and to pay for associated employer costs and other benefits as specified in Section 22.0763 for all employees directly employed by the facility on December 31, 2008, March 31, 2009, June 30, 2009, and September 30, 2009, except:

i. the administrator;
ii. central office staff of a corporation that has an ownership interest in the facility or exercises control over the facility; or
iii. persons paid by the facility under a management contract.

Two-thirds of the money available as described above in this section must be used for the Medicaid portion of an equal hourly percentage wage bonus wage increase for all eligible employees.

Facilities may apply for the portion of the rate adjustment described above in this section which shall be acted on by the commissioner as described in section 22.0763, item (6). The portion of the rate adjustment that is not part of the seventy-five percent described above in this section shall be provided to facilities effective October 1, 2008.

Effective July 1, 2023, each facility receives a temporary payment rate add-on of $12.35 per resident day. This rate add-on expires on December 31, 2024.

SECTION 22.0765 **Payment for post-PERA pension benefit costs**

Nursing facilities that convert or converted after September 30, 2006, from public to private ownership shall have a portion of their post-PERA pension costs treated as a component of the historic operating rate. Effective for the rate years beginning on or after October 1, 2009, and prior to October 1, 2016, the commissioner shall determine the pension costs to be included in the facility's base for determining rates under this section by using the following formula: post-privatization pension benefit costs as a percent of salary shall be determined from either the cost report for the first full reporting year after privatization or the most recent report year available, whichever is later. This percentage shall be applied to the salary costs of the alternative payment system base rate year to determine the allowable amount of pension costs. The adjustments provided for in sections 1.000 to 23.000 shall be applied to the allowable amount. The adjusted allowable amount shall be added to the operating rate effective the first rate year PERA ceases to remain as a pass-through component of the rate.

SECTION 22.0766 **Special diet adjustment**
For rate years beginning on or after August 1, 2010, in calculating a facility's operating cost per diem for the purposes of comparing to an array, a median, or other statistical measure of facility payment rates to be used to determine future rate adjustments, the Department will exclude adjustments for

raw food costs under Section 22.132, that are related to providing special diets based on religious beliefs.

SECTION 22.077 **Contract payment rates; appeals.** If a provider appeal is pending concerning the cost-based payment rates that are the basis for the calculation of the payment rate under the contractual alternative payment methodology, the Department and the nursing facility may agree on an interim contract rate to be used until the appeal is resolved. When the appeal is resolved, the contract rate must be adjusted retroactively in accordance with the appeal decision.

Section 22.078 **Rate adjustment for sprinkler federal compliance.** Beginning October 1, 2007, and ending September 30, 2008, a rate adjustment is available for 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. Facilities will receive reimbursement for the Medicaid portion of the costs associated with compliance if all of the following conditions are met:

A. the expenses associated with compliance occurred on or after January 1, 2005, and before December 31, 2008;
B. the costs were not otherwise reimbursed ; and
C. the total allowable costs reported are less than the minimum threshold established under sections 16.1372 and 16.1373.

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 according to the Department of Human Services' established credit balance process. 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.

SECTION 22.080 **Exemptions.** To the extent permitted by federal law:

A. Nursing facilities that are Medicare certified and filing a Medicare cost report and have entered into a contract under this section are not required to file a cost report as described in Section 2.000 for any year after the base year that is the basis for the calculation of the contract payment rate for the first rate year of the alternative payment contract. Nursing facilities that are not Medicare certified and are not filing a Medicare cost report must file a cost report as described in Section 2.000.

B. A facility under contract is not subject to audits of historical costs or revenues, or paybacks or retroactive adjustments based on these costs or revenues, except audits, paybacks, or adjustments relating to the cost report that is the basis for calculation of the first rate year under the contract, and all subsequent rate years affected by changes to that first rate year payment rate.

C. A facility that is under contract with the state under this section is not subject to the state's moratorium law on licensure or certification of new nursing home beds, unless the project results in a net increase in bed capacity or involves relocation of beds from one site to another. Contract payment rates must not be adjusted to reflect any additional costs that a nursing facility incurs as a result of a construction project undertaken under this paragraph.

D. As a condition of entering into a contract under Section 22.000, a nursing facility must agree that any future medical assistance payments for nursing facility services will not reflect any additional costs attributable to the sale of a nursing facility under the State plan or to construction undertaken under this section that otherwise would not be authorized under the moratorium exception process.

E. Nothing in this section prevents a nursing facility participating in the contractual alternative payment rate methodology described in this section from seeking approval of an exception to the state's nursing home moratorium law through the process established in that law. The projected costs of the moratorium exception project are not required to exceed the cost threshold, which is $1,000,000 plus inflation added annually for projects approved after July 1, 2001.

(1) If a moratorium exception application is approved, the nursing facility's payment rate for property shall be adjusted to reflect the cost of the approved project.

(2) If a nursing facility receives legislative approval of an exception to the moratorium, the facility’s rate must be adjusted to reflect the cost of the project.

F. Notwithstanding the state's law governing the level of nursing home Medicare certification, and pursuant to any terms and conditions contained in the facility's contract, a nursing facility contracting with the state under this section is in compliance with state laws if the nursing facility is Medicare certified.

G. A nursing facility under contract is allowed to change therapy arrangements from an unrelated vendor (i.e., a therapist not working for the nursing facility) to a related vendor during the term of the contract.

SECTION 22.090 **Consumer protection.**

A. As a condition of entering into a contract under this section, a nursing facility must agree to establish resident grievance procedures that are similar to those required under state law.

B. The nursing facility may also be required to establish expedited grievance procedures to resolve complaints made by short-stay residents.

C. The facility must notify its resident council of its intent to enter into a contract and must consult with the council regarding any changes in operation expected as a result of the contract.

SECTION 22.100 **Contracts are voluntary.**

A. Election by a nursing facility of the contractual alternative payment rate is voluntary.

B. The terms and procedures governing the alternative payment rates are determined under Section 22.000 and through negotiations between the Department and nursing facilities that have submitted a letter of intent to elect the alternative payment rate.

C. For purposes of developing requests for proposals and contract requirements, and negotiating the terms, conditions, and requirements of contracts, the Department is exempt from state rulemaking requirements.

SECTION 22.110 **Federal requirements.** The Department will implement the contractual alternative payment methodology subject to any required federal approvals, and in a manner that is consistent with federal requirements. If a provision of this section is inconsistent with a federal requirement, the federal requirement supersedes the inconsistent provision. The Department will seek federal approval and request waivers as necessary to implement this section.

SECTION 22.120 **Salary adjustments.** Effective July 1, 1998, made available the appropriate salary adjustment per diem calculated in Section 11.070 to the total operating cost payment rate of each nursing facility subject to payment under this section. This salary adjustment per diem became part of the operating payment rate in effect on June 30, 2001.

SECTION 22.130 **Separate billings for therapy services.** Nursing facilities must limit charges in total to vendors of therapy services for renting space, equipment, or obtaining other services during the rate year to the inflated amount from the facility's base year cost report. Nursing facilities that are

located in a county participating in the state's §1115 prepaid medical assistance waiver program are exempt from this maximum therapy rent revenue requirement.

SECTION 22.140 **Payment for preadmission screening fees.** The estimated annual cost of screenings for each nursing facility are included as an allowable operating cost for reimbursement purposes. The estimated annual costs are divided by the facility's actual resident days for the cost report period. The resulting per diem amount is included in the calculation of the total payment rate.

SECTION 22.150 **Noncompliance with baseline statistical and cost information.** If a nursing facility fails to comply with the baseline statistical and cost information requirements of state law that require such information by August 31, 2004, the Department shall reduce the nursing facility's payments to 85% of the amount they would otherwise have received. The reinstatement of withheld payments is retroactive for no more than 90 days.

SECTION 22.160 **Nursing facility rate adjustments beginning September 1, 2013.** A total of a five percent average rate adjustment shall be provided as described under this section and under section 22.076**.**

(a) Beginning September 1, 2013, the commissioner shall make available to each nursing facility reimbursed under this section a 3.75 percent operating payment rate increase, in accordance with paragraphs (b) to (g).

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

(1) wage and salary increases effective after May 25, 2013;

(2) the employer's share of 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 and workforce needs, including the recruiting and training of employees, subject to the approval of the commissioner.

(d) The portion of the rate adjustment under paragraph (a) that is not subject to the requirements of paragraph (b) shall be provided to nursing facilities effective September 1, 2013. Nursing facilities may apply for the portion of the rate adjustment under paragraph (a) that is subject to the requirements in paragraph (b). 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 paragraph (b);

(2) a detailed distribution plan specifying the allowable compensation-related 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 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.

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

(1) 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;

(2) 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, 2013, and prior to April 1, 2014; and

(3) 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, 2013. Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of this provision as having been met in regard to the members of the bargaining unit.

(f) The commissioner shall review applications received under paragraph (d) and shall provide the portion of the rate adjustment under paragraph (b) if the requirements of pargraph (b) are met. The rate adjustment shall be effective September 1, 2013. Notwithstanding paragraph (a), if the approved application distributes less money than is

available, the amount of the rate adjustment shall be reduced based on the ratio of the lower amount in the approved application to the amount available as specified in (b) so that the amount of money made available is equal to the amount to be distributed.
(g) The increase in this section shall be applied as a percentage to operating payment rates in effect on August 31, 2013. For each facility, the commissioner shall determine the operating payment rate, not including any rate components resulting from equitable cost-sharing for publicly owned nursing facility program participation under section 20.070, critical access nursing facility program participation under section 23.211, or performance-based incentive payment program participation under section 22.0761, for a RUG class with a weight of 1.00 in effect on August 31, 2013.

SECTION 23.000 **Calculation of nursing facility operating and external fixed payment rates.**

SECTION 23.010 **Calculation of nursing facility operating payment rates.**
The commissioner shall calculate operating payment rates using the statistical and cost report filed by each nursing facility for the report period ending 15 months prior to the rate year. Each cost reporting year shall begin on October 1 and end on the following September 30. Beginning in 2014, a statistical and cost report shall be filed by each nursing facility by February 1. Notice of rates shall be distributed by November 15 and the rates shall go into effect on January 1 for one year.

SECTION 23.020 **Reserved**

SECTION 23.030 **Reserved**

SECTION 23.040 **Reserved**

SECTION 23.050 **Definitions.**

Active beds. "Active beds" means licensed beds that are not currently in layaway status.

Activities costs. "Activities costs" means the costs for the salaries and wages of the supervisor and other activities workers, associated fringe benefits and payroll taxes, supplies, services, and consultants.

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, permits except as provided in the external fixed costs category, employee recognition, travel including meals and lodging, all training except as specified in direct care costs, voice and data communication or

transmission, office supplies, property and liability insurance and other forms of insurance except insurance that is a fringe benefit, 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, bad debts, bad debt collection fees, and costs incurred for travel and housing for persons employed by a supplemental nursing services agency and working in the facility.

Allowed costs. (a) "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.

(b) For facilities where employees are represented by collective bargaining agents, increases from the prior year in costs related to the salaries and wages, payroll taxes, and employer's share of fringe benefit costs, except employer health insurance costs, for facility employees who are members of the bargaining unit are allowed costs only if these costs are incurred pursuant to a collective bargaining agreement that was effective on the last day of the cost reporting year.

The commissioner shall allow until March 1 following the date on which the cost report was required to be submitted for a collective bargaining agent to notify the commissioner if a collective bargaining agreement was not in effect on the last day of the cost reporting year. If the collective bargaining agent notifies the commissioner by March 1 that a collective bargaining agreement was not in effect on the last day of the cost reporting year, the agent must then notify the commissioner by October 1 that these costs are incurred pursuant to an agreement or understanding between the facility and the collective bargaining agent in order for the above costs to be allowed.

(c) In any year for which a portion of a facility's reported costs are not allowed costs under paragraph (b), when calculating the operating payment rate for the facility, the commissioner shall use the facility's allowed costs from the facility's second most recent cost report in place of the nonallowed costs. For the purpose of setting the other operating payment rate, the rate shall be reduced by the difference between the nonallowed costs and the allowed costs from the facility's second most recent cost report.

Centers for Medicare & Medicaid Services. "Centers for Medicare & Medicaid Services or CMS" means the federal agency, in the United States Department of Health and Human Services that administers Medicaid.

Commissioner. "Commissioner" means the commissioner of human services unless specified otherwise.

Desk audit. "Desk audit" means the establishment of the payment rate based on the commissioner's review and analysis of required reports, supporting documentation, and work sheets submitted by the nursing facility.

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 include the salaries or fees of dietary consultants, dietary supplies, and food preparation and serving.

Direct care costs. "Direct care costs" means costs for the wages of nursing administration, direct care registered nurses, licensed practical nurses, certified nursing assistants, trained medication aides, employees conducting training on resident care topics, 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. Effective August 1, 2009, direct care costs also means wages of employees conducting training in resident care topics, costs of materials used for resident care training and training course outside of the facility attended by direct care staff on resident care topics. Effective October 1, 2017, direct care costs also means costs for nurse consultants, pharmacy consultants, and medical directors.

Employer health insurance costs. "Employer health insurance costs" means premium expenses for group coverage, actual expenses incurred for self-insured plans, including reinsurance; and employer contributions to employee health reimbursement and health savings accounts. Premium and expense costs and contributions are allowable for employees, and the spouse and dependents of those employees who are employed on average at least 30 hours per week. Employer costs for health insurance for spouse and dependents of part-time employees shall not be an allowable cost.

External fixed costs. "External fixed costs" means costs related to the nursing home surcharge; Minnesota Health Department licensure fees; family advisory council fees; scholarships; planned closure rate adjustments; single bed room incentives; property taxes; special assessments, and payments in lieu of taxes; employer health insurance costs, quality incentive payment rate adjustments; performance-based incentive payments; special dietary needs; rate adjustments under

23.212 effective on or after January 1, 2018; ~~and PERA~~ Public Employees Retirement Association employer costs and border city rate adjustments under section 23.133.

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 based on the system described in section 14.

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 as described in Section 20.030; and
(2) freestanding: all other facilities.

Field audit. "Field audit" means the examination, verification, and review of the financial records, statistical records, and related supporting documentation on the nursing home and any related organization.

Fringe benefit costs. "Fringe benefit costs" means the costs for group life; dental; workers' compensation; short- and long-term disability; long term care insurance; accident insurance; supplemental insurance; legal assistance insurance; profit sharing; other costs not considered employer health insurance costs, including costs associated with part-time employee family members or retirees; and pension and retirement plan contributions, except for the Public Employees Retirement Association.

Generally accepted accounting principles. "Generally Accepted Accounting Principles" means the body of pronouncements adopted by the American Institute of Certified Public Accountants regarding proper accounting procedures, guidelines, and rules.

Hospital-attached nursing facility status. (a) “Hospital-attached nursing facility" means a nursing facility which meets the requirements of clauses (1) and (2); or (3); or (4), or had hospital-attached status prior to January 1, 1995, and has been recognized as having hospital-attached status by CMS continuously since that date:

(1) the nursing facility is recognized by the federal Medicare program to be a hospital-based nursing facility;

(2) the hospital and nursing facility are physically attached or connected by a corridor;

(3) a nursing facility and hospital, which have applied for hospital-based nursing facility status under the federal Medicare program during the reporting year, shall be considered a hospital-attached nursing facility for purposes of setting payment rates under this section. The nursing facility must file its cost report for that reporting year using Medicare principles and Medicare's recommended cost allocation methods had the Medicare program's hospital-based nursing facility status been granted to the nursing facility. For each subsequent rate year, the nursing facility must meet the definition requirements in clauses (1) and (2). If the nursing facility is denied hospital-based nursing facility status under the Medicare program, the nursing facility's payment rates for the rate years the nursing facility was considered to be a hospital-attached nursing facility according to this paragraph shall be recalculated treating the nursing facility as a non-hospital-attached nursing facility;

(4) if a nonprofit or community-operated hospital and attached nursing facility suspend operation of the hospital, the remaining nursing facility must be allowed to continue its status as hospital-attached for rate calculations in the three rate years subsequent to the one in which the hospital ceased operations.

(b) The nursing facility's cost report filed as hospital-attached facility shall use the same cost allocation principles and methods used in the reports filed for the Medicare program. Direct identification of costs to the nursing facility cost center will be permitted only when the comparable hospital costs have also been directly identified to a cost center which is not allocated to the nursing facility.

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.

Laundry costs. "Laundry costs" means the costs for the salaries and wages of the laundry supervisor and other laundry employees, associated fringe benefits, and payroll taxes. It also includes the costs of linen and bedding, the laundering of resident clothing, laundry supplies, and contract services.

Licensee. "Licensee" means the individual or organization listed on the form issued by the Minnesota Department of Health.

Maintenance and plant operations costs. "Maintenance and plant operations costs" means the costs for the salaries and wages of the maintenance supervisor, engineers, 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.

Median total care-related cost per diem and other operating per diem determined.

(a) The commissioner shall determine the median total care-related per diem to be used in section 23.100 and the median other operating per diem to be used in section 23.120 using the cost reports from nursing facilities in Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties.

(b) The median total care-related per diem shall be equal to the median total care-related per diem for a RUG's weight of 1.00 for facilities located in the counties listed in paragraph (a).

(c) The median other operating per diem shall be equal to the median other operating per diem for facilities located in the counties listed in paragraph (a). The other operating per diem shall be the sum of each facility's administrative costs, dietary costs, housekeeping costs, laundry costs, and maintenance and plant operations costs divided by each facility's resident days.

Normalized direct care costs per day. "Normalized direct care costs per day" means direct care costs divided by standardized days. It is the costs per day for direct care services associated with a RUG's index of 1.00.

Nursing facility. "Nursing facility" means a facility with a medical assistance provider agreement that is licensed by the Department of Health as a nursing home or as a boarding care home which meets federal certification requirements for a nursing facility.

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.

Payroll taxes. "Payroll taxes" means the costs for the employer's share of the FICA and Medicare withholding tax, and state and federal unemployment compensation taxes.

Prior system operating cost payment rate. "Prior system operating cost payment rate" means the operating cost payment rate in effect on December 31, 2015, under Minnesota rules and Minnesota statutes, inclusive of health insurance plus property insurance costs from external fixed, but not including rate increases allowed under Section 20.070.

Private paying resident. "Private paying resident" means a nursing facility resident who is not a medical assistance recipient and whose payment rate is not established by another third party, including the Veterans Administration or Medicare.

Rate year. "Rate year" means the 12-month period beginning on January 1.

Raw food costs. "Raw food costs" means the cost of food provided to nursing facility residents and

the allocation of dietary credits. Also included are special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet.

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.

Reporting period. "Reporting period" means the one-year period beginning on October 1 and ending on the following September 30 during which incurred costs are accumulated and then reported on the statistical and cost report. If a facility is reporting for an interim or settle-up period, the reporting period beginning date may be a date other than October 1. An interim or settle-up report must cover at least five months, but no more than 17 months, and must always end on September 30.

Resident day or actual resident day. "Resident day" or "actual resident day" means a day for which nursing services are rendered and billable, or a day for which a bed is held and billed. The day of admission is considered a resident day, regardless of the time of admission. The day of discharge is not considered a resident day, regardless of the time of discharge.

Salaries and wages. "Salaries and wages" means amounts earned by and paid to employees or on behalf of employees to compensate for necessary services provided. Salaries and wages include accrued vested vacation and accrued vested sick leave pay. Salaries and wages must be paid within 30 days of the end of the reporting period in order to be allowable costs of the reporting period.

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.

Stakeholders. "Stakeholders" means individuals and representatives of organizations interested in long-term care, including nursing homes, consumers, and labor unions.

Standardized days. "Standardized days" means the sum of resident days by case mix category multiplied by the RUG index for each category. When a facility has resident days at a penalty classification, these days shall be reported as resident days at the RUG class established immediately after the penalty period, if available, and otherwise, at the RUG class in effect before the penalty began.

Statistical and cost report. "Statistical and cost report" means the forms supplied by the commissioner for annual reporting of nursing facility expenses and statistics, including instructions and definitions of items in the report.

Therapy costs. "Therapy costs" means any costs related to therapy services provided to residents that are not separately billable from the daily operating rate.

Section 23.060. **Reporting of statistical and cost information.** (a) All nursing facilities shall provide information annually to the commissioner on a form and in a manner determined by the commissioner. The commissioner may also require nursing facilities to provide statistical and cost information for a subset of the items in the annual report on a semiannual basis. Nursing facilities shall report only costs directly related to the operation of the nursing facility. The facility shall not include costs which are separately reimbursed by residents, medical assistance, or other payors. Allocations of costs from central, affiliated, or corporate office and related organization transactions shall be reported according to Section 3.040. Beginning with the September 30, 2013, reporting year, the commissioner shall no longer grant to facilities extensions to the filing deadline. The commissioner may separately require facilities to submit in a manner specified by the commissioner documentation of statistical and cost information included in the report to ensure accuracy in establishing payment rates and to perform audit and appeal review functions under this section. Facilities shall retain all records necessary to document statistical and cost information on the report for a period of no less than seven years. The commissioner may amend information in the report according to section 23.060. The commissioner may reject a report filed by a nursing facility under this section if the commissioner determines that the report has been filed in a form that is incomplete or inaccurate and the information is insufficient to establish accurate payment rates. In the event that a complete report is not submitted in a timely manner, the commissioner shall reduce the reimbursement payments to a nursing facility to 85 percent of amounts due until the information is filed. The release of withheld payments shall be retroactive for no more than 90 days. A nursing facility that does not submit a report or whose report is filed in a timely manner but determined to be incomplete shall be given written notice that a payment reduction is to be implemented and allowed

ten days to complete the report prior to any payment reduction. If circumstances exist that are unusual and outside of the normal course of business operations, the commissioner may delay the payment withhold at the sole discretion of the commissioner. An example of an exceptional circumstance would be the illness of several employees involved in cost report preparation.

(b) Nursing facilities may, within 12 months of the due date of a statistical and cost report, file an amendment when errors or omissions in the annual statistical and cost report are discovered and an amendment would result in a rate increase of at least 0.15 percent of the statewide weighted average operating payment rate and shall, at any time, file an amendment which would result in a rate reduction of at least 0.15 percent of the statewide weighted average operating payment rate. The commissioner shall make retroactive adjustments to the total payment rate of a nursing facility if an amendment is accepted. Where a retroactive adjustment is to be made as a result of an amended report, audit findings, or other determination of an incorrect payment rate, the commissioner may settle the payment error through a negotiated agreement with the facility and a gross adjustment of the payments to the facility. Retroactive adjustments shall not be applied to private pay residents. An error or omission for purposes of this item does not include a nursing facility's determination that an election between permissible alternatives was not advantageous and should be changed.

(c) If the commissioner determines that a nursing facility knowingly supplied inaccurate or false information or failed to file an amendment to a statistical and cost report that resulted in or would result in an overpayment, the commissioner shall immediately adjust the nursing facility's payment rate and recover the entire overpayment. The commissioner may also terminate the commissioner's agreement with the nursing facility and prosecute under applicable state or federal law.

Section 23.070. **Audit authority.** (a) The commissioner may subject reports and supporting documentation to desk and field audits to determine compliance with this section. Retroactive adjustments shall be made as a result of desk or field audit findings if the cumulative impact of the finding would result in a rate adjustment of at least 0.15 percent of the statewide weighted average operating payment rate. If a field audit reveals inadequacies in a nursing facility's record keeping or accounting practices, the commissioner may require the nursing facility to engage competent professional assistance to correct those inadequacies within 90 days so that the field audit may proceed.

(b) Field audits may cover the four most recent annual statistical and cost reports for which desk audits have been completed and payment rates have been established. The field audit must be an independent review of the nursing facility's statistical and cost report. All transactions, invoices, or other documentation that support or relate to the statistics and costs claimed on the annual statistical and cost reports are subject to review by the field auditor. If the provider fails to provide the field auditor access to supporting documentation related to the information reported on the statistical and cost report within the time period specified by the commissioner, the commissioner shall calculate the total payment rate by disallowing the cost of the items for which access to the supporting

documentation is not provided.

(c) Changes in the total payment rate which result from desk or field audit adjustments to statistical and cost reports for reporting years earlier than the four most recent annual cost reports must be made to the four most recent annual statistical and cost reports, the current statistical and cost report, and future statistical and cost reports to the extent that those adjustments affect the total payment rate established by those reporting years.

(d) The commissioner shall extend the period for retention of records under section 23.050 for purposes of performing field audits as necessary to enforce Minnesota Statutes, 256B.48 with written notice to the facility postmarked no later than 90 days prior to the expiration of the record retention requirement.

Section 23.080. **Calculation of care-related 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.

Section 23.090. **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.

Section 23.100. **Determination of total care-related limit.** (a) The median total care-related per diem shall be determined according to definition of median total-care related per diem in section 23.050.

(b) A facility's total care-related limit shall be a variable amount based on each facility's quality score, as determined under section 22.076, item (A):

(1) the quality score determined in section 22.076 shall be multiplied by 0.5625;

(2) add 89.375 to the amount determined in clause (1), and divide the total by 100; and;

(3) multiply the amount determined in clause (2) by the median total care-related per diem determined in section 23.050.

(c) A RUG's weight of 1.00 shall be used in the calculation of the median total care-related per diem, and in comparisons of facility-specific direct care costs to the median.

(d) A facility that is above its total care-related limit as determined according to paragraph (b) shall have its total care-related per diem reduced to its limit. If a reduction of the total care-related per

diem is necessary due to this limit, the reduction shall be made proportionally to both the direct care per diem and the other care-related per diem.

Section 23.110. **Reserved**

Section 23.120. **Determination of other operating price**. The price for other operating costs shall be determined as 105 percent of the median other operating per diem described in section 23.050.

Section 23.130. **Exception for specialized care facilities.**

(a) For rate years beginning on or after January 1, 2016, the care-related limit for specialized care facilities shall be increased by 50 percent.

(b) "Specialized care facilities" are facilities with specialized treatment programs for residents with physical disabilities, or is a facility with 96 beds on January 1, 2015, located in Robbinsdale that specializes in the treatment of Huntington's Disease.

Section 23.131. **Nursing facility in Golden Valley.** Effective for the rate year beginning January 1, 2016, and all subsequent rate years, the operating payment rate for a facility located in the city of Golden Valley with 44 licensed rehabilitation beds as of January 7, 2015, must be calculated without the application of the rate limit in section 23.100 and shall not be limited to the price determined in section 23.120.

Effective July 1, 2023, and expiring on June 30, 2025, the other operating payment rate, for a facility located at 1412 West 4th Street in the city of Red Wing, is the sum of its direct care costs per standardized day, its other care-related costs per resident day, and its other operating costs per day without the application of the rate limit in section 23.100 or the price determined in section 23.120.

Section 23.132. **Special dietary needs.** The Commissioner shall adjust the rates of a nursing facility that meets the criteria for the special dietary needs of its residents, including the requirements for kosher and halal products. The adjustment for raw food cost shall be the difference between the nursing facility's most recently reported allowable raw food cost per diem and 115 percent of the median allowable raw food cost per diem. For rate years beginning on or after January 1, 2016, this amount shall be removed from allowable raw food per diem costs under operating costs and included in the external fixed per diem rate under section 23.140.

Section 23.133.**Nursing facilities in border cities.** Effective for the rate year beginning January 1, 2016, and annually thereafter, operating payment rates of a non-profit nursing facility that exists on January 1, 2015, is located anywhere within the boundaries of the city of Breckenridge, and is reimbursed under this section, shall be adjusted to be equal to the median RUG's rates, including comparable rate components as determined by the Commissioner, for the equivalent RUG's weight of the nonprofit nursing facility or facilities located in an adjacent city in another state and in cities

contiguous to the adjacent city. The Minnesota facility's operating payment rate with a weight of 1.0 shall be computed by dividing the adjacent city's nursing facilities median operating payment rate with a weight of 1.02 by 1.02. If the adjustments under this subdivision result in a rate that exceeds the limits in section 23.120 in a given rate year, the facility's rate shall not be subject to those limits for that rate year. This section shall apply only if it results in a higher operating payment rate than would otherwise be determined under this section.

Effective for the rate year beginning on or after January 1, 2021, each eligible nonprofit facility located within the boundaries of the city of Breckenridge or Moorhead will receive a rate add-on to their external fixed rate if they apply via the application process and by the statutory deadline. The add-on to the external fixed costs payment rate is the difference on January 1 of the median total payment rate for case mix classification PA1 of the nonprofit facilities located in an adjacent city in another state and in cities contiguous to the adjacent city minus the eligible nursing facility's total payment rate for case mix classification PA1.

Section 23.140. **Calculation of payment rate for external fixed costs**. The commissioner shall calculate a payment rate for external fixed costs. The state will pay the Medicaid portion of the following calculated rate:

(a) For a facility licensed as a nursing home, the portion related to Minnesota Statutes, §256.9657, shall be equal to $8.86. For a facility licensed as both a nursing home and a boarding care home, the portion related to Minnesota Statutes, §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 Minnesota Department of Health licensure fee shall be the amount of the fee divided by actual resident days.

(c) The portion related to scholarships shall be determined under Section 20.060.

(d) The portion related to development and education of resident and family advisory councils shall be $5 divided by 365.

(e) The portion related to planned closure rate adjustments shall be as determined under Section 20.027.

(f) The portions related to 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.

(g) The portion related to the Public Employees Retirement Association shall be ~~actual~~ allowable costs divided by resident days.

(h) The single bed room incentives shall be as determined under Section 11.056B and Section 22.073B.

(i) The portion related to employer health insurance costs shall be the allowable costs divided by resident days.

(j) The portion related to special dietary needs shall be the per diem amount determined under section 23.132.

(k) The portion related to quality improvement shall be the allowable amount determined under section 22.076, item (B).

(l) The portion related to the performance incentive shall be the amount determined under section 22.0761.

(m) The portion related to consolidation rate adjustments shall be the amount determined under section 20.115.

(n) The payment rate for external fixed costs shall be the sum of the amounts in paragraphs (a) ~~to (p)~~ through (q).

(o) Costs for pre-approved property assessed clean energy project.

(p) For rate years effective on or after January 1, 2021, the rate adjustments for border city facilities under section 23.133.

(q) The portion related to the rate adjustment for the critical access nursing facilities under section 23.211.

Section 23.150. **Determination of total payment rates**. 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, external fixed cost rate, and the property rate determined under section 22.060. To determine the care-related payment rate for each RUG's level, multiply each RUG's weight by the direct care portion of the care-related per diem.

23.160. **Reserved**

Section 23.170. **Hold harmless**. (a) For the rate years beginning on or after January 1, 2016, no nursing facility shall receive a cost payment rate, including the property insurance portion of operating costs plus health insurance component of external fixed, less than its cost payment rate under the prior system, which included operating costs inclusive of health insurance costs plus the

property insurance component of external fixed. The comparison of payment-rate components under this section shall be made for a RUG's rate with a weight of 1.00.

(b) For rate years beginning on or after January 1, 2016, no facility shall be subject to a reduction of the care-related payment-rate limit greater than five percent of the median determined in section 23.150.

Section 23.180. **Appeals**. Nursing facilities may appeal, as described under Minnesota Statutes, §256B.50, the determination of a payment rate established under this section.

Section 23.190. **Reserved**

Section 23.200 **Reserved**

Section 23.210 **Reserved**

Section 23.211 **Critical access nursing facilities.**

Effective July 1, 2012, (a) the commissioner of human services, in consultation with the commissioner of health, may designate certain nursing facilities as critical access nursing facilities. The designation shall be granted on a competitive basis, within the limits of funds appropriated for this purpose.

(b) The commissioner shall request proposals from nursing facilities every two years. Proposals must be submitted in the form and according to the timelines established by the commissioner. In selecting applicants to designate, the commissioner, in consultation with the commissioner of health, and with input from stakeholders, shall develop criteria designed to preserve access to nursing facility services in isolated areas, rebalance long-term care, and improve quality. Beginning in fiscal year 2015, to the extent practicable, the commissioner shall ensure an even distribution of designations across the state.

(c) Nursing facilities designated as critical access nursing facilities will receive reimbursement according to clauses (1) to (5):

(1) partial rebasing, with operating payment rates being the sum of up to 60 percent of the operating payment rate determined in accordance with section 23.150 and at least 40 percent of the operating payment rate that would have been allowed had the facility not been designated as a critical access nursing facility, with the sum of the two portions being equal to 100 percent. The commissioner may adjust these percentages by up to 20 percent and may approve a request for less than the amount allowed; (2) enhanced payments for leave days. Upon designation as a critical access nursing facility, the commissioner shall limit payment for leave days to 60 percent of that nursing facility's total payment rate for the involved resident, and shall allow this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 90 percent; (3) two designated critical access nursing facilities, with up to 100

beds in active service, may jointly apply to the commissioner of health for a waiver in order to jointly employ a director of nursing; (4) the minimum threshold under section 16.1374, item E shall be 40 percent of the amount that would otherwise apply; and (5) the quality-based rate limits under section 23.100 shall apply to designated critical access nursing facilities.
(d) Designation of a critical access nursing facility shall be for a period of two years, after which the benefits allowed under paragraph (c) shall be removed. Designated facilities may apply for continued designation.
(e) This section is suspended from January 1, 2016, to December 31, 2019.

Effective July 1, 2023, in lieu of partial rebasing of operating payment rates, a nursing facility designated as a critical access nursing facility will receive a supplemental payment above a facility's operating payment rate as determined to be necessary to maintain access to nursing facilities in isolated areas. The amount of the supplemental payment will be approved through a memorandum of understanding, will be time limited rate adjustments included in the external fixed cost payment rate undersection 23.140. The memorandum of understanding must state that the designation of a critical access nursing facility is removed if the nursing facility undergoes a change of ownership.

Section 23.212 **Rate adjustments for compensation-related costs**

Effective for rate years beginning on and after October 1, 2014, (a) Operating payment rates of all nursing facilities that are reimbursed under this section or section 22 shall be increased annually to address changes in compensation costs for nursing facility employees paid less than $14 per hour. Rate increases under this section or section 22, effective prior to October 1, 2016, expire effective January 1, 2018. Rate increases under this section or section 22, effective on or after October 1, 2016, expire effective January 1, 2019.

(b) Based on the application in paragraph (d), the commissioner shall calculate the allowable annualized compensation costs by adding the totals of clauses (1), (2), and (3). The result is divided by the standardized or resident days from the most recently available cost report to determine per diem amounts, which must be included in the operating portion of the total payment rate and allocated to direct care or other operating costs as determined by the commissioner:

(1) the sum of the difference between $8 and any hourly wage rate less than $8 for October 1, 2014; between $9 and any hourly wage rate less than $9 for October 1, 2015; between $9.50 and any hourly wage rate less than $9.50 for October 1, 2016; and between the indexed value of the minimum wage, as defined by state law and any hourly wage less than that indexed value for rate years beginning on and after October 1, 2017; multiplied by the number of compensated hours at that wage rate;

(2) using wages and hours in effect during the first three months of calendar year 2014, beginning with the first pay period beginning on or after January 1, 2014; 33.3 percent of the sum of items (i) to (viii) for October 1, 2014; 44.4 percent of the sum of items (i) to (viii) for October 1, 2015; and 22.2 percent of the sum of items (i) to (viii) for October 1, 2016;

(i) for all compensated hours from $8 to $8.49 per hour, the number of compensated hours is multiplied by $0.13;

(ii) for all compensated hours from $8.50 to $8.99 per hour, the number of compensated hours is multiplied by $0.25;

(iii) for all compensated hours from $9 to $9.49 per hour, the number of compensated hours is multiplied by $0.38;

(iv) for all compensated hours from $9.50 to $10.49 per hour, the number of compensated hours is multiplied by $0.50;

(v) for all compensated hours from $10.50 to $10.99 per hour, the number of compensated hours is multiplied by $0.40;

(vi) for all compensated hours from $11 to $11.49 per hour, the number of compensated hours is multiplied by $0.30;

(vii) for all compensated hours from $11.50 to $11.99 per hour, the number of compensated hours is multiplied by $0.20; and

(viii) for all compensated hours from $12 to $13.00 per hour, the number of compensated hours is multiplied by $0.10; and

(3) the sum of the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, pensions, and contributions to employee retirement accounts attributable to the amounts in clauses (1) and (2).

(c) For the rate years beginning October 1, 2014, and later, nursing facilities that receive approval of the applications in paragraph (d) must receive rate adjustments according to paragraph (b). The rate adjustments must be used to pay compensation costs for nursing facility employees paid less than $14 per hour.

(d) To receive a rate adjustment, nursing facilities must submit applications to the commissioner that include specified data, and spending plans that describe how the funds from the rate adjustments will be allocated for compensation to employees paid less than $14

per hour. The applications must be submitted within three months of the effective date of any operating payment rate adjustment under this section. Within three weeks of receiving a complete application, the commissioner will request any additional information needed to determine the rate adjustment. The nursing facility must provide any additional information requested by the commissioner within six months of the effective date of any operating payment rate adjustment under this section. The commissioner may waive the deadlines in this section under extraordinary circumstances.

(e) For nursing facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the applications described in paragraph (d) only upon receipt of a letter, or letters, of acceptance of the spending plans in regard to members of the bargaining unit, signed by the exclusive bargaining agent and dated after May 31, 2014. Upon receipt of the letter, or letters, of acceptance, the commissioner shall deem all requirements of this section as having been met in regard to the members of the bargaining unit.

Section 23.213 **Temporary property rate add-on.**

(a) Effective January 1, 2025, a 225-bed facility in Ramsey County will receive a temporary property-rate increase of $10.65 per day. This increase will expire upon the effective date this facility transitions to the Fair Rental Value property rate system or May 31, 2026, whichever is earlier.

(b) Effective January 1, 2025, an 88-bed facility in St. Louis County will receive a temporary property-rate increase of $20.81 per day. This increase will expire upon the effective date this facility transitions to the Fair Rental Value property rate system or May 31, 2026, whichever is earlier.

(c) Effective January 1, 2025, a 78-bed facility in Fillmore County will receive a temporary property-rate increase of $21.35 per day. This increase will expire upon the effective date this facility transitions to the Fair Rental Value property rate system or May 31, 2026, whichever is earlier.

(d) Effective January 1, 2025, through June 30, 2025, a 105-bed facility in Ottertail County will receive a temporary property-rate increase of $38.56 per day.

METHODS AND STANDARDS FOR DETERMINING PAYMENT RATES FOR ICF/MR SERVICES PROVIDED IN STATE-OWNED FACILITIES

PURPOSE AND SCOPE:

This plan describes the methods and standards for determining payment rates for services provided in State-owned intermediate care facilities for the mentally retarded (ICFs/MR).

In general, per diem payment rates are determined annually on an interim basis with final settlement occurring after each State fiscal year.

METHODOLOGY:

Payment rates for State-owned ICFs/MR are determined annually on a cost-related basis using Medicare principles of reimbursement as specified in *Provider Reimbursement Manual* - HCFA 15, parts I and II, with the following exceptions.

Interim rates are calculated on a per diem basis for each State fiscal year (July 1 to June 30) by dividing the sum of anticipated allowable costs by the projected patient days.

Allowable costs include salaries, current expenses (fuel, utilities, food, drugs, and other expenses), repairs and betterments, depreciation of buildings and equipment, building bond interest, other capital requirements, and other expenses related to patient care, such as central office support (program supervisory staff), collections administration, other indirect costs (department personnel, medical director, information systems, and program analysis), statewide support costs (central payroll, statewide personnel), and other state agency support to State facilities. Projected patient days are determined from population estimates, based upon actual patient days and trends shown from prior years.

Final rates are determined at the end of the fiscal year by dividing total costs by in-house patient days and therapeutic visit days. For State-owned ICFs/MR, both in-house patient days

and therapeutic visit days are included as days paid under Medicaid as specified in Attachment 4.19-C. The occupancy rate required by Attachment 4.19-C does not apply to State-owned ICFs/MR.

METHODS AND STANDARDS FOR DETERMINING PAYMENT RATES FOR NURSING FACILITY SERVICES PROVIDED IN STATE-OWNED FACILITIES

PURPOSE AND SCOPE:

This plan describes the methods and standards for determining payment rates for nursing facility (NF) services provided in State-owned facilities.

In general, per diem payment rates are determined annually on an interim basis with final settlement occurring after each State fiscal year.

METHODOLOGY:

Payment rates for State-owned nursing facilities are determined annually on a cost-related basis using Medicare principles of cost reimbursement ~~as specified in *Provider Reimbursement Manual - HCFA 15, parts I and II, with the following exceptions*~~. Interim payments are made prior to the settle-up to final, cost-based rate after the close of the State fiscal year.

Interim rates are calculated on a per diem basis for each state fiscal year (July 1 to June 30) for ~~individual~~ each State-owned nursing ~~homes~~ home by dividing the sum of allowable anticipated costs by the projected patient days. Allowable anticipated costs are calculated using the Medicare principles of cost reimbursement prior to the change to prospective payment on October 1 ,2001, using the same methodology described below for final rates, against projected costs for the current State fiscal year. The interim rate shall not exceed the final rate for the previous State fiscal year.

~~Anticipated costs include salaries, current expenses (fuel, utilities, food, drugs, and other expenses), repairs and betterments, depreciation of buildings and equipment, building bond interest, other capital requirements, and other expenses related to patient care, such as central office support (program supervisory staff), collections administration, other indirect costs (department personnel, medical director, information systems, and program analysis), and statewide support costs (central payroll, statewide personnel), and other State agency support to State facilities. Projected patient days are determined from population estimates, based upon actual patient days and trends shown from prior years.~~

~~The per diem limits calculated under the Medicare principles of reimbursement are evaluated under Section 1861 (v)(1) which methodology is set out in Medicare Reimbursement Manual, HCFA 15-I, Section 2828. This calculation, as provided by the Medicare intermediary, establishes the routine service cost limit.~~

~~To arrive at the interim Medicaid per diem rate, the Medicare routine service limit is modified by adding to it the projected ancillary service costs, physician service costs, property related costs, and other costs not subject to the routine service limit.~~

The final ~~rates are~~ rate is determined ~~by dividing the total routine service costs subject to the limitation by the patient days. The net allowable routine costs are added to the capital, ancillary, professional and other costs not subject to the limit. The sum of the allowable routine service costs and the cost not subject to the limit are divided by patient days to arrive at the actual reimbursed costs~~ as follows: The routine service cost limit is calculated using the Medicare principles of cost reimbursement in effect prior to the change to prospective payment on October 1, 2001, except that the State may use a reasonable estimate as a proxy for any indices or statistic formerly used in the Medicare cost reimbursement rate that is no longer published. The routine service cost limit is modified by adding to it the ancillary service costs, physician service costs, capital related costs, and other costs not subject to the routine service limit. The sum is then divided by the number of patient days.

RATES TO NURSING FACILITIES TAKE INTO ACCOUNT THE COSTS OF NURSING FACILITIES' COMPLIANCE WITH THE REQUIREMENTS OF §1919(b) [OTHER THAN PARAGRAPH (3)(F)], (c) and (d).

The payment rates to nursing facilities were adjusted, effective January 1, 1990, to take into account the costs of nursing facilities' compliance with the requirements of §1919(b) [other than paragraph (3)(F)], (c) and (d). In the rate years following that one-time adjustment, including the most recent rate year, which began July 1, 1996, costs associated with these requirements have been incorporated into each facility's per diem rate based on data submitted by each facility in its annual cost reports.

The costs of nurse aide training and competency are reimbursed as an expense necessary for the proper and efficient administration of the Medicaid program.

Minnesota has a long history of providing high quality long-term care services. Many state laws and rules regulate the type and amount of services that must be provided and included in the basic per diem rate. The case mix system utilized for nursing facility cost reimbursement is based on the individual needs of facility residents. Facilities are required to meet individual resident's needs and are reimbursed accordingly.

Under the Minnesota case mix reimbursement system, residents are classified in one of eleven categories (A-K). The "A" case mix classification is the lowest; persons classified at the "A" level require the least amount of physical care and assistance with activities of daily living. The "K" case mix classification is the highest; persons classified at the "K" level require the most assistance with activities of daily living. An "A" is given a weight of 1 (one unit of case mix); a "K" a weight of 4.12.

A resident day is a day for which nursing services are rendered and billable. A standardized day is the sum of the number of resident days in each resident case mix class (A through K) multiplied by the weight for that resident class. Each standardized day reflects 1.0 unit of case mix (that is, an "A" equals 1.0 unit of case mix, and a "K" equals 4.12 units of case mix). Nursing hours are all on-duty hours of nurses, nurse aides, orderlies, and attendants. The on-duty hours of the director of nursing for facilities with more than 60 licensed beds and the on-duty hours of any medical records personnel are not included in nursing hours. Vacation, holidays, sick leave, classroom training, and lunch hours are not included.

Pre-OBRA state requirements mandated that NFs (former SNFs and ICF-Is) provide a minimum of 2.0 nursing hours per resident day and 0.95 nursing hours per standardized day. In 1995, the average reported number of nursing hours per resident day for NFs was 2.96; the average reported number of nursing hours per standardized day for NFs is 1.21. This shows that facilities provide, on average, more nursing hours than required. The chart below illustrates the number of nursing

hours provided in reporting NFs for the period from October 1, 1994 through September 30, 1995 (the most recent available report year).

TOTAL NURSING HOURS - REPORT YEAR 1995*

Total productive nursing hours:	36,002,105
Total resident days[1] (all facilities):	12,144,752
Total standardized days[2]:	29,653,236

* Nursing facilities participating in the alternative payment project no longer report these statistics

AVERAGE AND MINIMUM NURSING HOURS REQUIREMENT

	Average	Minimum Required
Nursing hours per resident day	2.96	2.00
Nursing hours per standardized day (per unit of case mix)	1.21	0.95

1 Resident day: A day for which nursing services are rendered and billable.

2 Standardized day: The sum of the number of resident days in each resident case mix class (A through K) multiplied by the weight for that resident class. Each standardized day reflects one unit of case mix (that is, an "A" equals 1.0 unit of case mix and a "K" equals 4.12 units of case mix).

Payment rates in Minnesota nursing facilities have risen steadily in the last several years. The weighted average daily payment rate for the rate year beginning July 1, 1987 was $55.76, and the average daily payment rate for the period beginning July 1, 1996 was $99.35, an increase of 78 percent over nine years.

The inflation factor used in the calculation of payment rates for nursing facilities was the forecasted Data Resources, Inc. Consumer Price Index - all items (US City Average). This index is projected forward to account for anticipated economic pressures on such items as wages. The 21-month factor utilized for the rate year beginning July 1, 1996 was 4.99 percent for both care-related costs and other operating costs.

Because of the stringent requirements that were in effect prior to the implementation of the requirements of §1919(b), (c), and (d), many nursing facilities in Minnesota were able to meet those requirements with little additional cost. The norm of service provision and staffing levels in Minnesota nursing facilities was higher than pre-OBRA '87 federal and state requirements mandated. A detailed analysis of the differences between the pre-OBRA '87 facility licensure and certification requirements and the NF requirements, effective October 1, 1990, demonstrated that former skilled nursing facilities (SNFs) needed to make very few changes to comply with the October 1, 1990 federal regulations, and they consequently felt very little financial impact.

However, former intermediate care facilities (ICFs) had several areas where the pre-OBRA requirements were less stringent than the October 1, 1990 requirements, and the financial impact on those facilities, particularly the former freestanding ICF-IIs, was more significant. These facilities' higher costs were taken into account in determining the rate increases necessary to bring these facilities into compliance with the October 1, 1990 requirements.

Minnesota has a prospective payment system. Annually, except for facilities with contract rates, payment rates are calculated based on historical costs reported by facilities. There is a delay between the actual expenditures and the inclusion of those expenditures in payment rates. [Since July 1, 1995, nursing facilities which have received approval to contract with the State for their services have had an alternative rate-setting methodology -- the prior year's rate, plus inflation (CPI-U)]. Because of this prospective rate-setting method, it was preferable to provide up-front rate adjustments for the increased costs of meeting the OBRA '87 requirements in order to lessen the financial impact of the changes on providers.

To enable nursing facilities to meet OBRA requirements, the reimbursement rates were adjusted as of January 1, 1990. This provided nursing facilities with nine months of increased rates to upgrade their staffing and operations prior to the effective date of the new requirements. These adjustments were in effect for 18 months, until June 30, 1992. This allowed the inclusion of the increased costs in the reporting year that began October 1, 1990 and which ended September 30, 1991. The costs in the September 30, 1991 cost report were reflected in the July 1, 1992 rates, which became effective immediately after the expiration of the one-time OBRA rate adjustment on June 30, 1992. Additional incurred facility costs that can be included in per diem rates are allowable up to the established limits.

METHODS AND STANDARDS FOR DETERMINING PAYMENT RATES FOR SERVICES PROVIDED BY INTERMEDIATE CARE FACILITIES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES (ICFs/DD) THAT ARE NOT PAID ON A COST BASIS

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METHODS AND STANDARDS FOR DETERMINING PAYMENT RATES FOR SERVICES PROVIDED BY INTERMEDIATE CARE FACILITIES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES (ICFs/DD) THAT ARE NOT PAID ON A COST BASIS

SECTION 1.000 INTRODUCTION.

Section 1.010 **General purpose.** The purpose of Minnesota's methods and standards for determining medical assistance payment rates for ICFs/DD that are not paid on a cost basis is to provide for rates in conformity with applicable state and federal laws, regulations and quality and safety standards. Minnesota has in place a public process that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act. In determining the rates, the Department of Human Services takes into account the provider's historical costs, the size of the facility, and other factors.

Facilities participating in the Minnesota Medical Assistance Program are paid by a prospective rate-setting methodology, based upon a contracting system. This methodology, established in Minnesota statutes, is described in this attachment.

Facilities contract with the Department in order to receive payment. Contracts include descriptions of payments that may be modified when significant changes occur in residents' needs, the establishment and use of a quality improvement plan, appropriate and necessary statistical information required by the Department, annual aggregate facility financial information, and additional requirements for facilities not meeting the standards set forth in each contract.

Section 1.020 **Rate methodology.** The total payment rate for ICFs/DD in existence as of October 1, 2000, is the sum of the operating payment rate and the property payment rate.

Section 1.030 **Definitions.** For the purposes of Sections 2.000 to 9.060, the following terms have the meanings given them in this section.

Capacity days. "Capacity days" means the total number of licensed beds in the facility multiplied by the number of days in the reporting year.

Capital assets. "Capital assets" means a facility's land, physical plant, land improvements, depreciable equipment, leasehold improvements, capitalized improvements and repairs, and all additions to or replacement of those assets.

Capital debt. "Capital debt" means a debt incurred by the facility for the purpose of purchasing a capital asset, to the extent that the proceeds of the debt were actually applied to purchase the capital asset including points, financing charges, and bond premiums or discounts. Capital debt includes debt incurred for the purpose of refinancing a capital debt.

Class A beds. "Class A beds" means beds licensed for ambulatory and mobile persons who are capable of taking appropriate action for self-preservation under emergency conditions as determined by state and federal licensing law.

Class B beds. "Class B beds" means beds for ambulatory, nonambulatory, mobile, or nonmobile persons who are not mentally or physically capable of taking appropriate action for self-preservation under emergency conditions as determined by state and federal licensing law.

Commissioner. "Commissioner" means the commissioner of the Minnesota Department of Human Services.

Day services. “Day services” means services or supports provided to a resident that enables the resident to be fully integrated into the community. Day services may include supported work, support during community activities, day training and habilitation, community volunteer activity, adult day care, recreational activities, and other individualized integrated supports.

Department. "Department" means the Minnesota Department of Human Services.

Depreciable equipment. "Depreciable equipment" means the standard moveable resident care equipment and support service equipment generally used in an ICF/DD. Depreciable equipment includes the equipment specified in the major moveable equipment table of the depreciation guidelines.

Depreciation guidelines. "Depreciation guidelines" means The Estimated Useful Lives of Depreciable Hospital Assets, issued by the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois (Chicago: 1983). The depreciation guidelines are incorporated by reference and are available for reference at the Minnesota State Law Library, Minnesota Judicial Center, 25 Constitution Avenue, Saint Paul, Minnesota, 55155. Only the 1983 publication will be used and will not change.

Desk audit. "Desk audit" means the Department’s review and analysis of required reports, supporting documentation, and work sheets submitted by the provider.

Direct cost. "Direct cost" means a cost that can be identified within a general cost category without the use of allocation methods.

Facility. "Facility" or "ICF/DD" means a program licensed to serve persons with developmental disabilities or related conditions under state laws, and a physical plant licensed as a supervised living facility under state laws, which together are certified by the Minnesota Department of Health as an intermediate care facility for the developmentally disabled .

Fringe benefits. "Fringe benefits" means workers' compensation insurance (including self-

insurance plans), group health insurance, disability insurance, dental insurance, group life insurance, and retirement benefits or plans.

Leasehold improvement. "Leasehold improvement" means an improvement to property leased by the provider for the use of the facility that reverts to the owner of the property upon termination of the lease.

Medical assistance program. "Medical assistance program" means the program that reimburses the cost of health care provided to eligible residents pursuant to state and federal law.

Modified property payment rate. “Modified property payment rate” means the actual property payment rate exclusive of the effect of gains or losses on disposal of capital assets or adjustments for excess depreciation claims.

Necessary service. "Necessary service" means a function pertinent to the facility's operation that if not performed by the assigned individual would have required the provider to employ or assign another individual to perform it.

Occupancy report. “Occupancy report” means the report submitted monthly by a facility indicating bed use data by client for the preceding month.

Payroll taxes. "Payroll taxes" means the employer's share of social security withholding taxes, and state and federal unemployment compensation taxes or costs.

Physical plant. "Physical plant" means the building or buildings in which a program licensed to provide services to persons with developmental disabilities or related conditions under state law is located, and all equipment affixed to the building and not easily subject to transfer as specified in the building and fixed equipment tables of the depreciation guidelines, and auxiliary buildings in the nature of sheds, garages, and storage buildings located on the same site if related to resident care, and the allocated portion of office space if the office is located in that facility. Physical plant does not include buildings or portions of buildings used by central**,** affiliate, or corporate offices if those offices are not located in that facility**.**

Private paying resident. "Private paying resident" means a facility resident whose care is not paid for by the medical assistance program, cost of care program, or the Community Social Services Block Grant for the date of service.

Program. "Program" means those functions and activities of the facility that contribute to the care, supervision, developmental growth, and skill acquisition of the residents under state and federal laws.

Provider. "Provider" means the corporation, governmental unit, partnership, person, or persons licensed to operate the facility, which controls the facility's operation, incurs the costs reported,

and claims reimbursement under Sections 1.010 to 9.060 or the care provided in the facility.

Provider group. "Provider group" means a parent corporation, any subsidiary corporations, partnerships, management organizations, and groups of facilities operated under common ownership or control that incurred the costs shown on the income and expense report that are claimed for reimbursement under Sections 1.010 to 9.060.

Quality improvement plan. "Quality improvement plan" means the document submitted by a facility to the Department describing the facility's quality improvement process.

Rate adjustment. "Rate adjustment" means a rate change granted by the Department. The amount available for rate adjustments is set by legislative appropriation.

Rate year. For the initial year, "rate year" means the period for which the total payment rate is effective, from October 1, 2000 through December 31, 2001. Thereafter, "rate year" means a calendar year.

Related organization. "Related organization" means a person that furnishes goods or services to a facility and that is a close relative of a provider or a provider group, an affiliate of a provider or provider group, or an affiliate of a close relative of an affiliate of a provider or provider group. For the purposes of this definition, the following terms have the meanings given them.

A. "Affiliate" means a person that directly, or indirectly though 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 provider or provider group" means an individual whose relationship by blood, marriage, or adoption to an individual who is an affiliate of a provider or provider group 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.

Repair. "Repair" means the cost of labor and materials needed to restore an existing capital asset to sound condition after damage or malfunction or to maintain an existing capital asset in a usable condition.

Reporting year. "Reporting year" means the period from January 1 to December 31 immediately preceding the rate year, for which the provider submits its income and expense report.

Resident day. "Resident day" means a day on which services provided to residents are rendered and billable, or a day for which a bed is held and billed.

Statewide advisory committee. "Statewide advisory committee" means the committee charged with reviewing county and provider proposals and making recommendations to the Department regarding facility payment rate adjustments. The committee uses established criteria for ranking proposals in order to make recommendations.

Total payment rate. "Total payment rate" means the amount established by the commissioner to reimburse the provider for service provided to each resident. The total payment rate is calculated by adding the operating payment and the property payment rate.

Variable rate. A rate approved by the Department, upon the recommendation of the county of financial responsibility, when there is a documented increase in the needs of a resident. A documented increase is a demonstrated medical or behavioral need that significantly impacts the type or amount of services needed by a resident.

SECTION 2.000 GENERAL REPORTING REQUIREMENTS.

Section 2.010 **Required income and expense reports.** By April 30 of each year, the provider must submit an annual income and expense report on the form prescribed by the Department in order to receive medical assistance payments. The reports must cover the reporting year ending the previous December 31.

Section 2.020 **Required information.** A complete income and expense report contains the following items:

A. Salaries and related expenses, including salaries to program, administrative, and support staff, payroll taxes and fringe benefits, and training.

B. General operating expenses, including supplies, repairs, purchased services and consultants, utilities, food, licenses and fees, real estate taxes, insurance, and working capital interest.

C. Property-related expenses, including real estate taxes, depreciation, capital debt interest, rent and leases, and property insurance.

D. Facility income, including receipt of all income from accounts receivable related to facility operations.

E. Annual resident days.

Section 2.030 **Occupancy reports.**

A. A facility must maintain and submit monthly bed use data. The total payments made to a facility may be adjusted based on concurrent changes in the needs of recipients that are covered by a variable rate adjustment. Any adjustment for multiple resident changes does not result in a decrease to the facility base rate.

B. Bed use data will also indicate leave days and vacancies.

Section 2.040 **Deadlines, extensions, and rejections.**

A. A facility that terminates participation in the Medical Assistance Program during a reporting year must submit the required annual income and expense report covering the period from January 1 of that reporting year to the date of termination. The income and expense report must be submitted within four months after termination.

B. The Department may reject any annual income and expense report filed by a facility that is incomplete or inaccurate, or for which supplemental information is required. In these cases, the Department will inform the facility what additional information is required. The facility will be given a reasonable amount of time to supply the information.

Failure to file the required income and expense report and other required information constitutes a material breach of the contract, allowing the Department to pursue termination of the contract.

Section 2.050 **False reports.** If a provider knowingly supplies inaccurate or false information on an income and expense report, the Department will exercise its options under the breach of terms provisions in its contract with the facility.

Section 2.060 **Adequate documentation.** A facility must keep adequate documentation.

A. In order to be considered adequate, documentation must:

(1) be maintained in orderly, well-organized files;

(2) not include documentation of more than one facility in one set of files unless transactions may be traced by the Department to the facility's annual income and expense report;

(3) include a paid invoice or copy of a paid invoice with date of purchase, vendor name and address, purchaser name and delivery address, listing of items or services purchased, cost of items purchased, account number to which the cost is posted, and a breakdown of any allocation of costs between accounts or facilities. If any of the information to

be listed on the invoice is not available, the providers must document their good faith attempt to obtain the information;

(4) include copies of all written agreements and debt instruments to which the facility is a party and any related mortgages, financing statements, and amortization schedules to explain the facility's costs and revenues;

(5) if a cost or revenue item is not documented under subitem (3) or (4), the facility must document the amount, source, and purpose of the item in its books and ledgers following generally accepted accounting principles and in a manner providing an audit trail; and

(6) be retained by the facility to support the five most recent annual income and expense reports submitted to the Department. The Department may extend the period of retention if the desk audit was postponed because of inadequate record keeping or accounting practice, or if the records are necessary to resolve a pending appeal.

B. Providers must document all consultant, professional, or purchased service contracts. They must maintain copies of all contracts and invoices relating to consultant, professional, or purchased services. These documents must include the name and address of the vendor or contractor, the name of the person who actually performed the services, the dates of service, a description of the services provided, the unit cost, and the total cost of the service.

C. Payroll records must be maintained by a facility and must show the amount of compensation paid to each employee and the days and hours worked. Complete and orderly cost allocation records must be maintained for cost allocations made among cost categories or facilities.

SECTION 3.000 QUALITY IMPROVEMENT PLAN.

A. Except for the initial rate year, by the March following the end of each rate year, facilities must submit reports regarding the previous year’s quality improvement plans to the Department. For the initial rate year, facility quality improvement plans must be submitted by December 31, 2000.

B. Each quality improvement plan must identify a minimum of one performance measure on which to focus during the contract period.

C. Elements of a quality improvement plan:

(1) a facility-specific quality improvement team;

(2) area(s) of need (and why), including the strategies used to identify the causes;

(3) definition of the quality improvement goal or benchmark;

(4) identified data sources;

(5) plan of action and strategies to address the problem;

(6) summarized and interpreted data; and

(7) evaluation of the results, including how the quality improvement plan is communicated to residents, staff, and residents' families, and how the process is monitored and changed as needed.

SECTION 4.000 DETERMINATION OF TOTAL PAYMENT RATE.

Section 4.010 **Total payment rate.** The total payment rate is the sum of the operating payment rate and the property payment rate.

A. Operating payment rate.

(1) The operating payment rate is the facility's total payment rate in effect on September 30, 2000, minus the property rate. It includes the efficiency incentive in effect as of September 30, 2000.

(2) Within the limits of appropriations for this purpose, the operating payment rate is increased for each rate year by the annual percentage change in the Employment Cost Index for Private Industry Workers–Total Compensation in the second quarter of the **calendar year** preceding the start of the rate year. For the initial rate year, the percentage change is based on the percentage change in the Employment Cost Index for Private Industry Workers–Total Compensation for the 15-month period from October 1, 2000 through December 31, 2001, as forecast by Data Resources, Inc.

(3) The operating payment rate is adjusted to reflect an occupancy rate equal to 100 percent of a facility's capacity days as of September 30, 2000, except that effective July 1, 2009, through June 30, 2013, no occupancy rate adjustment will be applied.

(4) For the initial rate year, the Department will make an adjustment to the operating payment rate for a facility that submits a plan, approved by the Department, in accordance with unit (b). Operating costs will be separated into compensation-related costs and

all other costs. Compensation-related costs means allowable program operating cost category employee training expenses and allowable salaries, payroll taxes, and fringe benefits for all employees except the administrator and central office staff.

(a) Facilities that have rates governed by closure agreements, receivership agreements, or interim rates are not eligible for these adjustments.

(b) The payment rate is increased by:

1) 6.6 percent of compensation-related costs, 45 percent of which must be used to increase the per-hour pay rate of all employees except administrative and central office employees by an equal dollar amount and to pay associated costs for FICA, the Medicare tax, workers' compensation premiums, and federal and state unemployment insurance provided that this portion of the compensation-related increase must be used only for wage increases implemented on or after October 1, 2000, and must not be used for wage increases implemented before that date;

2) and 2.0 percent of all other operating costs.

A facility's most recent cost report submitted for desk audit will be used to calculate the adjustment.

(c) To receive the operating payment rate adjustment, a facility must apply to the Department. The application must contain a plan by which the facility will distribute the compensation-related portion of the payment rate adjustment to employees of the nursing facility. For a facility 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 only if the agreement is finalized after May 16, 2000.

1) The Department will review the plan to ensure that the payment rate adjustment is used as provided in unit (b).

2) To be eligible, a facility must submit its plan for the payment rate adjustment by December 31, 2000. If a facility's plan for the payment rate adjustment is effective for its employees after October 1 of the year that the funds are available, the payment rate adjustment shall be effective the same date as its plan.

(d) The Department will determine the payment rate adjustment using the categories listed above multiplied by the rate increases in unit (b), divided by the facility's actual resident days.

(5) Effective July 1, 2001, the Department will make an adjustment to the operating

payment rate of 3.5 percent for a facility that submits a plan, approved by the Department. Of this adjustment, two-thirds must be used in accordance with unit (a) and one-third must be used for operating costs.

(a) Two-thirds of the adjustment must be used to increase the wages and benefits and pay associated costs of all employees except administrative and central office employees, provided that this increase is used only for wage and benefit increases implemented on or after July 1, 2001.

(b) For each facility, the Department will make available an adjustment by multiplying 3.5 percent by the total payment rate in effect on June 30, 2001, excluding the property-related payment rate.

(c) The application for the rate adjustment must contain a plan by which the facility will distribute the adjustment in unit (a) to employees of the facility. For a facility 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 only if the agreement is finalized after June 30, 2001.

1) The Department will review the plan to ensure that the payment rate adjustment per diem is used as provided in this subitem.

2) To be eligible, a facility must submit its plan for the rate adjustment by March 31, 2002. If a facility's plan for the payment rate adjustment is effective for its employees after July 1, 2001, the payment rate adjustment is effective the same date as its plan.

(d) A facility that has payment rate governed by closure agreements or receivership agreements cannot receive an adjustment.

(6) Effective July 1, 2002, the Department will make an adjustment to the operating payment rate of 3.5 percent for a facility that submits a plan, approved by the Department. Of this adjustment, two-thirds must be used in accordance with unit (a) and one-third must be used for operating costs.

(a) Two-thirds of the adjustment must be used to increase the wages and benefits and pay associated costs of all employees except administrative and central office employees, provided that this increase is used only for wage and benefit increases implemented on or after July 1, 2002.

(b) For each facility, the Department will make available an adjustment by multiplying 3.5 percent by the total payment rate in effect on June 30, 2002, excluding the property-related payment rate.

(c) The application for the rate adjustment must contain a plan by which the facility will distribute the adjustment in unit (a) to employees of the facility. For a facility 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 only if the agreement is finalized after June 30, 2002.

1) The Department will review the plan to ensure that the payment rate adjustment per diem is used as provided in this subitem.

2) To be eligible, a facility must submit its plan for the rate adjustment by March 31, 2003. If a facility's plan for the payment rate adjustment is effective for its employees after July 1, 2002, the payment rate adjustment is effective the same date as its plan.

(d) A facility that has payment rate governed by closure agreements or receivership agreements cannot receive an adjustment.

(7) Effective April 1, 2002, the operating payment rate is adjusted for increases in licensing fees paid by facilities.

(8) Effective July 1, 2003, the operating payment rate in effect on June 30, 2002 is reduced by one percent. Facilities with payment rates governed by a receivership agreement in Sections 7.000 or 8.000, or by a closure agreement in Section 9.010, are not subject to this item.

(9) Effective October 1, 2005, the operating payment rate is increased by 2.2553 percent for a facility that submits a plan, approved by the Department. Of this increase, two-thirds must be used in accordance with unit (a).

(a) Two-thirds of the increase must be used to increase the MA portion of wages and benefits and pay associated MA costs of all employees except administrative and central office employees, provided that this increase is used only for wage, benefit, and staff increases implemented on or after October 1, 2005.

(b) For each facility, the Department will make available an increase by multiplying 2.2553 percent by the total payment rate in effect on September 30, 2005, excluding the property-related payment rate.

(c) The application for the rate increase must contain a plan by which the facility will distribute the increase in unit (a) to employees of the facility. For a facility 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 only if the agreement is finalized after July 15, 2005.

(1) The Department will review the plan to ensure that the payment rate increase per diem is used in accordance with unit (a).

(2) To be eligible, a facility must submit its plan by March 31, 2006. If a facility's plan for the payment rate increase is effective for its employees after October 1, 2005, the increase is effective the same date as its plan.

(d) Facilities that have rates governed by closure agreements, receivership agreements, or interim rates are not eligible for these increases.

(10) Effective October 1, 2006, the operating payment rate is increased by 2.2553 percent for a facility that submits a plan, approved by the Department. Of this increase, two-thirds must be used in accordance with unit (a).

(a) Two-thirds of the increase must be used to increase the MA portion of wages and benefits and pay associated MA costs of employees except administrative and central office employees, provided that this increase is used only for wage, benefit, and staff increases implemented on or after October 1, 2006.

(b) For each facility, the Department will make available an increase based on occupied beds.

(c) The application for the increase must contain a plan by which the facility will distribute the increase in unit (a) to employees of the facility. For a facility 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 only if the agreement is finalized after July 15, 2006.

(1) The Department will review the plan to ensure that the payment rate increase per diem is used in accordance with unit (a).

(2) To be eligible, a facility must submit its plan by December 31, 2006. If a facility's plan for the payment rate increase is effective for its employees after October 1, 2006, the payment rate increase is effective the same date as its plan.

(d) Facilities that have rates governed by closure agreements, receivership agreements, or interim rates are not eligible for these increases.

(11) Effective October 1, 2007, the operating payment rate is increased by 2 percent for a facility that submits a plan, approved by the Department. Of this increase, three-fourths must be used in accordance with unit (a).

(a) The rate increase must be used to increase the MA portion of wages and

benefits and pay associated MA costs of employees directly employed by the facility except administrative, or central office, employees or persons paid under a management contract, provided that this increase is used only for wage, benefit, and staff increases implemented on or after October 1, 2007.

(b) Two-thirds of the increase described in unit (a) must be paid as an equal hourly percentage wage increase to the MA portion of wages for employees directly employed by the facility effective on the same date for all eligible employees. This provision does not apply to employees represented by an exclusive bargaining representative.

(c) For the purposes of units (a) and (b) compensation related costs include:

(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 Department.

(d) For each facility, the Department will make available an increase not subject to units (a) and (b), based on occupied beds and effective October 1, 2007

(e) Increases subject to units (a) and (b) will be based on the lesser of the amount distributed as wage increases in accordance with units (a) and (b) or the amount of the percentage rate increase based on occupied beds.

(f) The application for the increase must contain a plan by which the facility will distribute the increase in units (a) and (b) to employees of the facility. For a facility 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 effective the later of July 15, 2007 or Departmental receipt of a letter of acceptance of the wage distribution plan by the exclusive bargaining representative.

(g) The Department shall ensure that cost increases in distribution plans under unit (f)(2)(ii), 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 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

Department 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.

(h) Facilities that have rates governed by closure agreements, receivership agreements, or interim rates are not eligible for these increases.

(12) Effective October 1, 2008, the operating payment rate is increased by 2 percent for a facility that submits a plan, approved by the Department. Of this increase, three-fourths must be used in accordance with unit (a).

(a) The rate increase must be used to increase the MA portion of wages and benefits and pay associated MA costs of employees directly employed by the facility except administrative, or central office, employees or persons paid under a management contract, provided that this increase is used only for wage, benefit, and staff increases implemented on or after October 1, 2008.

(b) Two-thirds of the increase described in unit (a) must be paid as an equal hourly percentage wage increase to the MA portion of wages for employees directly employed by the facility effective on the same date for all eligible employees. This provision does not apply to employees represented by an exclusive bargaining representative.

(c) For the purposes of units (a) and (b) compensation related costs include:
(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 Department.

(d) For each facility, the Department will make available an increase not subject to units (a) and (b), based on occupied beds and effective October 1, 2008

(e) Increases subject to units (a) and (b) will be based on the lesser of the amount distributed as wage increases in accordance with units (a) and (b) or the amount of the percentage rate increase based on occupied beds.

(f) The application for the increase must contain a plan by which the facility will distribute the increase in units (a) and (b) to employees of the facility. For a facility 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 effective the later of July 15, 2007 or Departmental receipt of a letter of acceptance of the wage distribution plan by the exclusive bargaining representative.

(g) The Department shall ensure that cost increases in distribution plans under unit (f)(2)(ii), 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, 2007, and prior to the first day of the facility's payroll period that includes October 1, 2008, 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 Department 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, 2008, and prior to April 1, 2009.

(h) Facilities that have rates governed by closure agreements, receivership agreements, or interim rates are not eligible for these increases.

(13) Effective July 1, 2009 the operating payment rate is decreased by 2.58 percent and the provisions in sub-items 12(a) through 12(g) no longer apply.

(14) Effective for July 1, 2014, the operating payment rate is increased by 5 percent for a facility that submits a plan, approved by the Department. Of this increase, 80 percent must be used in accordance with unit (a).

(a) The rate increase must be used to increase the MA portion of compensation costs of employees directly employed by the facility except central office employees or persons paid under a management contract.

(b) For the purpose of unit (a), compensation related costs include:
(1) wages and salaries;
(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, and mileage reimbursement;
(3) the employer's share of health and dental insurance, life insurance,

disability insurance, long-term care insurance, uniform allowance, pensions, and contributions to employee retirement accounts; and

(4) other benefits provided and workforce needs, subject to the approval of the Department.

(c) For each facility, the Department will make available an adjustment by multiplying 5 percent by the total payment rate in effect on June 30, 2014, excluding the property-related payment rate.

(d) To receive the operating payment rate adjustment, a facility must apply to the Department. The application must contain a plan by which the facility will distribute the compensation-related portion of the payment rate adjustment to employees of the nursing facility.

For public employees under a collective bargaining agreement, the increase for wages and benefits is available and pay rates must be increased only to the extent that the increases comply with laws governing public employees' collective bargaining. Money received by a facility for pay increases for public employees must be used only for pay increases implemented between July 1, 2014, and August 1, 2014.

For a facility that has employees that are represented by an exclusive bargaining representative, the provider shall obtain a letter of acceptance of the distribution plan, in regard to the members of the bargaining unit, signed by the exclusive bargaining agent.

(e) Effective January 1, 2015, the Department shall decrease by 1 percent the payment rate of any facility that fails to submit the plan described in paragraph (d).

(15) Effective January 1, 2022, the operating payment rate is increased by 5 percent.

(a) For each facility, the Department will make an adjustment by multiplying 5 percent by the total payment rate in effect on December 31, 2021, excluding the property-related payment rate.

(16) Effective January 1, 2024, the operating payment rate is increased by $40.

(a) For each facility, the Department will make an increase of $40 of the total payment rate in effect on December 31, 2023, excluding the property-related payment rate.

(17) Effective January 1, 2024, class A facilities have an operating payment rate floor of $275 and class B facilities have an operating payment rate floor of $316.

a) For each class A facility that is below the operating payment rate floor after the

increase applied in paragraph (16), the Department will make an adjustment to increase the operating payment rate to $275.

b) For each class B facility that is below the operating payment rate floor after the increase applied in paragraph (16), the Department will make an adjustment to increase the operating payment rate to $316.

(18) Effective January 1, 2025, and each year thereafter, the operating payment floors in paragraph (17) are increased to account for inflation, as measured by change in the CPI- U.

B. Property payment rate.

(1) The property payment rate is based on the facility's modified property payment rate in effect on September 30, 2000. The modified property payment rate is the actual property payment rate exclusive of the effect of gains or losses on disposal of capital assets or adjustments for excess depreciation claims.

(2) Effective October 1, 2000, a minimum property payment rate of $8.13 is applied to all existing facilities. Effective October 1, 2000, facilities with modified property payment rates effective September 30, 2000 below the minimum property payment rate receive an increase equal to the difference between the minimum property payment rate and the modified property payment rate in effect on September 30, 2000. Effective October 1, 2000, facilities with modified property payment rates effective September 30, 2000 at or above the minimum property payment rate receive the modified property payment rate.

(3) Within the limits of appropriations for this purpose, effective January 1, 2002, facility property payment rates are increased annually for inflation. The increase is based on each facility's property payment rate in effect on September 30, 2000.

(4) Modified property payment rates effective September 30, 2000 are arrayed from the highest to lowest before applying the minimum property payment rate in subitem (2).

(a) For modified property payment rates at the 90th percentile or above, the annual inflation increase is zero.

(b) For modified property payment rates below the 90th percentile but at least at the 75th percentile, the annual inflation increase is one percent.

(c) For modified property payment rates below the 75th percentile, the annual

inflation increase is 2 percent.

Section 4.020 **Increase in payment rate beginning June 6, 2003.**

Each facility receives an increase in its payment rate of $3.00, which is added following the determination of the payment rate for each facility. This increase is not subject to any annual percentage increase.

Section 4.030 **Limitations to total payment rate.** The total payment rate must not exceed the rate paid by private paying residents for similar services for the same period.

Section 4.040 **Increase in payment rate beginning March 1, 2006.** Effective March 1, 2006 and ending September 30, 2007, payment for ICF/DD services is increased by .2% for those providers who applied and met the competitive requirements for a medical assistance payment rate increase for the purpose of employee scholarships, except that the increase is .3% effective on or after September 1, 2006, for those providers who agree to accept the higher rate on a contract entered into on or after March 1, 2006 or whose new contract was entered into on or after September 1, 2006.

Section 4.050 **Payment rates for new facilities in Hennepin County.** Upon completion of relocation, the two six-bed level B facilities licensed to replace a 15 bed level A facility that is inaccessible to persons with disabilities will receive a payment rate of $200.47 per day plus any rate adjustments effective on or after July 1, 2007.

Section 4.060 **Payment rates for new facilities in Chisholm and Hibbing**. Effective for admissions on or after October 1, 2009 the newly licensed six-bed, level B facility in Chisholm will receive a payment rate of $274.50 per day and the newly licensed six-bed level B facility in Hibbing will receive a payment rate of $250.84 per day plus any rate adjustments effective on or after October 1, 2009.

Section 4.070 **Payment rates for certain facilities in Clearwater County**. Effective for admissions on or after July 1, 2010 through June 30, 2011, the per diem rate for a Class A facility with 15 beds in Clearwater County is increased from $112.73 to $138.23.

Section 4.080 **Payment rates for certain facilities in Kandiyohi County**. Effective for admissions on or after July 1, 2010 through June 30, 2011, the per diem rate for a six bed Class A facility is increased by $43.04.

Section 4.090 **Payment rates for certain facilities in Clearwater County.** Effective for admissions on or after September 1, 2011, the per diem rate for a Class A facility with 15 beds in Clearwater County is increased from $112.73 to 138.23.

Section 4.091 **Payment rates for certain facilities in Cottonwood County.** Effective for

admissions on or after July 1, 2013, the per diem rate for a facility with 18 beds in Cottonwood County shall adjust to $282.62.

Section 4.092 **Payment rates for certain facilities in Murray County.** Effective for admissions on or after July 1, 2017, the per diem rate for a facility with 14 beds in Murray County shall adjust to $400 per day plus any rate adjustments effective on July 1, 2017.

Section 4.100 **Decrease in payment rate.** On September 1, 2011, each facility, except for a Class A facility located in Clearwater County with 15 beds, shall receive a decrease of .095 percent to the operating payment rate and all variable rates in effect on August 31, 2011.

Section 4.110 **Decrease in payment rate.** On September 1, 2011, each facility shall receive a decrease of 1.5 percent to the operating payment rate and all variable rates in effect on August 31, 2011.

Reserved

Section 4.130 **Increase in payment rate beginning July 1, 2013.** Effective for admissions on or after July 1, 2013, each facility shall receive an increase in its payment rate of $7.81, which is added following the determination of the payment rate for each facility. This increase is not subject to any annual percentage increase.

Section 4.140 **Increase in payment rate beginning July 1, 2013.** Effective for admissions on or after July 1, 2013, each facility shall receive an increase of .5 percent to the operating payment rate and all variable rates in effect on June 30, 2013.

Section 4.150 **Increase in payment rates beginning April 1, 2014.** Effective for admissions on or after April 1, 2014, each facility shall receive an increase of 1 percent to the operating payment rate and all variable rates in effect on March 31, 2014.

Section 4.160 **Increase in payment rates beginning January 1, 2021.** Effective for admissions on or after January 1, 2021, each facility shall receive an increase of 5 percent to the operating payment rate and all variable rates in effect on December 31, 2021.

SECTION 5.000 DAY SERVICES CHARGES.

A. Charges incurred by the ICF/DD for day services provided by an entity licensed as a day training and habilitation provider are paid as a pass-through payment. The pass-through payment is paid separately and is not included in the computation of the total payment rate. Effective March 1, 2006 and ending September 30, 2007, payment for day services is increased by .2% for those providers who applied and met the competitive bidding requirements for a medical assistance payment rate increase for the purpose of employee scholarships, except that the increase is .3% on or after September 1, 2006, for those providers who agree to accept the

higher rate on a contract entered into on or after March 1, 2006 or whose new contract was entered into on or after September 1, 2006. Effective October 1, 2007 payment for day services is increased by 2%. Providers receiving this rate increase must comply with the requirement of unit (1). Effective October 1, 2008 payment for day services is increased by 2%. Providers receiving this rate increase must comply with the requirements of unit (1). Effective July 1, 2009 payment for day services is reduced by 2.58 percent. Effective January 1, 2024 payment for day services is increased by 14.99 percent.

(1) Seventy-five percent of the rate increases effective October 1, 2007 and July 1, 2008 must be used to increase the MA portion of wages and benefits and pay associated MA costs of employees directly employed by the facility except administrative, or central office, employees or persons paid under a management contract, provided that this increase is used only for wage, benefit, and staff increases implemented on or after October 1, 2008.

(2) Two-thirds of the increase must be paid as an equal hourly percentage wage increase to the MA portion of wages for employees directly employed by the facility effective on the same date for all eligible employees. This provision does not apply to employees represented by an exclusive bargaining representative.

(3) For the purposes of units (1) and (2) compensation related costs include:

(a) wages and salaries;

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

(c) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions.

(4) For public employees, the increase for wages and benefits for certain staff is available and pay rates must be increased only to the extent that they comply with laws governing public employees collective bargaining.

(5) Providers receiving the rate increase shall provide to the Department within six months of the rate increase, a letter that provides assurances that the provider has developed and implemented a compensation plan and complied with units (1) and (2).

B. By January 1, 2004, charges incurred by the ICF/DD for day services provided by a licensed entity that is not licensed as a day training and habilitation provider will be paid separately and will not be included in the computation of the total payment rate. Rates for day services will not exceed 100 percent of a resident's day services costs prior to leaving a day training and habilitation program. Effective March 1, 2006 and ending September 30, 2007, payment for day services is increased by .2% for those providers who applied and met the competitive requirements for a medical assistance payment rate increase for the purpose of employee scholarships, except that the increase is .3% effective on or after September 1, 2006, for those providers who agree to accept the higher rate on a contract entered into on or after

March 1, 2006 or whose new contract was entered into on or after September 1, 2006.

SECTION 6.000 APPEAL PROCEDURES.

Section 6.010 **Scope of appeals.**

A provider may appeal from a determination of a payment rate established pursuant to this Attachment if the appeal, if successful, would result in a change to the provider's payment rate. Appeals must be filed in accordance with procedures in this section.

Section 6.020 **Filing of appeals.**

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

Section 6.030 **Contested case procedures appeals review process.**

A. Effective for desk audit appeals on or after October 1, 2000, the Commissioner must review appeals and issue a written appeal determination on each appeals item within one year of the due date of the appeal. Upon mutual agreement, the Commissioner and the provider may extend the time for issuing a determination for a specified period. The Commissioner must notify the provider by first class mail of the appeal determination. The appeal determination takes effect 30 days following the date of issuance specified in the determination.

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

C. For an appeal item with which the provider disagrees with the appeal determination, the provider may file with the Commissioner a written demand for a contested case hearing to determine the proper resolution of specified appeal items. The demand must be postmarked or received by the Commissioner within 30 days of the date of issuance specified in

the determination. A contested case demand for an appeal item nullifies the written appeal determination issued by the Commissioner for that appeal item. The Commissioner must refer any contested case demand to the office of the Attorney General.

D. A contested case hearing must be heard by an administrative law judge. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the determination of a payment rate is incorrect.

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

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

Section 6.040 **Attorney's fees and costs.**

A. For an issue appealed under Section 6.010, the prevailing party in a contested case proceeding or, if appealed, in subsequent judicial review, must be awarded reasonable attorney's fees and costs incurred in litigating the appeal, if the prevailing party shows that the position of the opposing party was not substantially justified. The procedures for awarding fees and costs set forth in state law regarding procedures for award of fees in contested cases must be followed in determining the prevailing party's fees and costs except as otherwise provided in this section. For purposes of this section, "costs" means subpoena fees and mileage, transcript costs, court reporter fees, witness fees, postage and delivery costs, photocopying and printing costs, amounts charged the Commissioner by the office of administrative hearings, and direct administrative costs of the Department; and "substantially justified" means that a position had a reasonable basis in law and fact, based on the totality of the circumstances prior to and during the contested case proceeding and subsequent review.

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

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

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

E. Attorney fees and costs awarded to the Department for proceedings under this section must not be reported or treated as allowable costs on the provider's income and expense report.

F. Fees and costs awarded to a provider for proceedings under this section must be reimbursed to them within 120 days of the final decision on the award of attorney fees and costs.

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

H. Amounts collected by the Commissioner pursuant to this section must be deemed to be recoveries.

Section 6.050 **Legal and related expenses.** Legal and related expenses for unresolved challenges to decisions by governmental agencies must be separately identified and explained on the provider's income and expense report for each year in which the expenses are incurred. When the challenge is resolved in favor of the governmental agency, the provider must notify the Department of the extent to which its challenge was unsuccessful on the income and expense report filed for the reporting year in which the challenge was resolved. In addition, the provider must inform the Department of the years in which it claimed legal and related expenses and the amount of the expenses claimed in each year relating to the unsuccessful challenge. The Department must reduce the provider's medical assistance rate in the subsequent rate year by the total amount claimed by the provider for legal and related expenses incurred in an unsuccessful challenge to a decision by a governmental agency.

SECTION 7.000 VOLUNTARY RECEIVERSHIP.

Section 7.010 **Receivership agreement.** A majority of controlling individuals of a residential program may at any time ask the Department to assume operation of the residential program through appointment of a receiver. On receiving the request, the Department may enter into an

agreement with a majority of controlling individuals and become the receiver and operate the program under conditions acceptable to both the Department and the majority of controlling individuals. The agreement will specify the terms and conditions of the receivership and preserve the rights of the persons being served by the program. A receivership set up under this section terminates at the time specified by the parties to the agreement.

Section 7.020 **Management agreement.** When the Department agrees to become the receiver of a program, the Department may enter into a management agreement with another entity or group to act as the managing agent during the receivership period. The managing agent will be responsible for the day-to-day operations of the residential program subject at all times to the review and approval of the Department. A reasonable fee may be paid to the managing agent for the performance of these services**.**

Section 7.030 **Rate adjustment.** The sections on rate recommendations and adjustments to the rate found in Section 8.000 also apply to voluntary receiverships.

Section 7.040 **Controlling individuals; restrictions on licensure.** No controlling individual of a residential program placed into receivership under Section 7.000 must apply for or receive a license to operate a program for five years from the commencement of the receivership period. Section 7.000 does not apply to programs that are owned or operated by controlling individuals, that were in existence prior to the date of the receivership agreement, and that have not been placed into receivership.

Section 7.050 **Liability.** The controlling individuals of a residential program placed into receivership remain liable for any claims made against the residential program that arose from incidents or events that occurred prior to the commencement of the receivership period. Neither the Department nor the managing agent of the Department assumes this liability.

Section 7.060 **Liability for financial obligations.** Neither the Department nor the managing agent will be liable for payment of any financial obligations of the residential program or of its controlling individuals incurred prior to the commencement of the receivership period unless such liability is expressly assumed in the receivership agreement. Those financial obligations remain the liability of the residential program and its controlling individuals. Financial obligations of the residential program incurred after the commencement of the receivership period are the responsibility of the Department or the managing agent to the extent such obligations are expressly assumed by each in the receivership or management agreements. The controlling individuals of the residential program remain liable for any financial obligations incurred after the commencement of the receivership period to the extent these obligations are not reimburse in the rate paid to the residential program and are reasonable and necessary to the operation of the residential program. These financial obligations, or any other financial obligations incurred by the residential program prior to the commencement of the receivership period that are necessary to the continued operation of the residential program, may be deducted from any rental payments owed to the controlling receivership agreement.

Section 7.070 **Physical plant of the residential program.** Occupation of the physical plant after commencement of the receivership period will be controlled by items A and B.

A. If the physical plant of a residential program placed in receivership is owned by a controlling individual or related party, the physical plant may be used by the Department or the managing agent for purposes of the receivership as long as the receivership period continues. A fair monthly rental will be paid by the Department or the managing agent to the owner of the physical plant. This fair monthly rental will be determined by considering all relevant factors necessary to meet required arms-length obligations of controlling individuals. This rental will not include any allowance for profit or be based on any formula that includes an allowance for profit.

B. If the owner of the physical plant is not a related party, the controlling individual shall continue as the lessee of the property. However, during the receivership period, rental payments shall be made to the owner of the physical plant by the Department or the managing agent on behalf of the controlling individual. Neither the Department nor the managing agent assumes the obligations of the lease unless expressly stated in the agreement. Should the lease expire during the receivership, the Department or the managing agent may negotiate a new lease for the term of the receivership period.

Section 7.080 Receivership costs. The Department may use the accounts and funds that would have been available for the room and board, services, and program costs of persons in the residential program for costs, cash flow, and accounting purposes related to the receivership.

SECTION 8.000 INVOLUNTARY RECEIVERSHIP.

Section 8.010 **Application.** In addition to any other remedy provided by law, the Department may petition the district court in the county where the program is located for an order directing the controlling individuals of the program to show cause why the Department should not be appointed receiver to operate the program. The petition must contain proof by affidavit: (1) that the Department has either begun license suspension or revocation proceedings, suspended or revoked a license, or has decided to deny an application for licensure of the program; or (2) it appears to the Department that the health, safety, or rights of the residents may be in jeopardy because of the manner in which the program may close, the program's financial condition, or violations committed by the program of federal or state laws or rules. If the license holder, applicant, or controlling individual operates more than one program, the Department's petition will specify and be limited to the residential program for which it seeks receivership. The affidavit submitted must set forth alternatives to receivership that have been considered, including rate adjustments. The order to show cause is returnable not less than five days after service is completed and must provide for personal service of a copy to the program administrator and to the persons designated as agents by the controlling individuals to accept

service on their behalf.

Section 8.020 **Appointment of receiver.** If the court finds that involuntary receivership is necessary as a means of protecting the health, safety, or rights of persons being served by the program, the court will appoint the Department as receiver to operate the program. The Department may contract with another entity or group to act as the managing agent during the receivership period. The managing agent will be responsible for the day-to-day operations of the program subject at all times to the review and approval of the Department.

Section 8.030 **Powers and duties of the receiver.** Within 36 months after the receivership order, the receiver will provide for the orderly transfer of the persons served by the program to other residential programs or make other provisions to protect their health, safety, and rights. The receiver or managing agent will correct or eliminate deficiencies in the program that the Department determines endanger the health, safety, or welfare of the persons being served by the residential program unless the correction or elimination of deficiencies involves major alteration in the structure of the physical plant. If the correction or elimination of the deficiencies requires major alterations in the structure of the physical plant, the receiver will take actions designed to result in the immediate transfer of persons served by the program. During the period of the receivership, the receiver and the managing agent will operate the program in a manner designed to preserve the health, safety, rights, adequate care, and supervision of the persons served by the program. The receiver or the managing agent may make contracts and incur lawful expenses. The receiver or the managing agent shall collect incoming payments from all sources and apply them to the cost incurred in the performance of the functions of the receivership. No security interest in any real or personal property comprising the residential program or contained within it, or in any fixture of the physical plant, shall be impaired or diminished in priority by the receiver or the managing agent.

Section 8.040 **Liability and liability for financial obligations.** These are the same as those for voluntary receivership that are found in Section 7.000.

Section 8.050 **Physical plant of the residential program.** Occupation of the physical plant is governed by the following:

A. The physical plant owned by a controlling individual of the residential program or related party must be made available for the use of the program throughout the receivership period. The court will determine a fair monthly rental for the plant, taking into account all relevant factors necessary to meet required arms-length obligations of controlling individuals. The rental fee must be paid by the receiver to the appropriate controlling individuals or related parties for each month that the receivership remains in effect. No payment made to a controlling individual or related party by the receiver or the managing agent or any state agency during a period of the receivership shall include any allowance for profit or be based on any formula that includes an allowance for profit.

B. If the owner of the physical plant of a program is not a related party, the court will order the controlling individual to continue as the lessee of the property during the receivership period. Rental payments during the receivership period shall be made to the owner of the physical plant by the Department or the managing agent on behalf of the controlling individual.

Section 8.060 **Fee.** A receiver or the managing agent is entitled to a reasonable fee as determined by the court.

Section 8.070 **Termination.** An involuntary receivership terminates 36 months after the date on which it was ordered or at any other time designated by the court or when any of the following occurs:

A. The Department determines that the program's license application should be granted or should not be suspended or revoked.

B. A new license is granted to the program.

C. The Department determines that all persons residing in the program have been provided with alternative residential programs.

D. The residential program closes.

Section 8.080 **Emergency procedure**. If it appears from the petition filed or from the affidavit filed with the petition or from testimony of witnesses under oath, that there is probable cause to believe that an emergency exists in a program, the court must issue a temporary order for appointment of a receiver within five days after receipt of the petition. Notice of the petition must be served on the residential program administrator and on the persons designated as agents by the controlling individuals to accept service on their behalf. A hearing on the petition must be held within five days after notice is served unless the administrator or designated agent consents to a later date. After the hearing, the court may continue, modify, or terminate the temporary order.

Section 8.090 **Rate recommendation.** The Department may review rates of a program participating in the Medical Assistance Program that is in receivership and that has needs or deficiencies documented by the Department of Health or the Department of Human Services. If the Department determines that a review of the rate established is needed, the Department will:

A. Review the order or determination that cites the deficiencies or needs.

B. Determine the need for additional staff, additional annual hours by type of employee, and additional consultants, services, supplies, equipment, repairs, or capital assets necessary to satisfy the needs or deficiencies.

Section 8.100 **Adjustment to the rate.** Upon review of rates the Department may adjust the program's payment rate. The Department will review the circumstances, together with the most recent residential program income and expense report, to determine whether or not the deficiencies or needs can be corrected or met by reallocating residential program staff, costs, revenues, or any other resources including investments. If the Department determines that any deficiency cannot be corrected or the need cannot be met with the payment rate currently being paid, the Department must determine the payment rate adjustment by dividing the additional annual costs established during the Department's review by the residential program's actual resident days from the most recent income and expense report or the estimated resident days in the projected receivership period. The payment rate adjustment remains in effect during period of the receivership or until another date set by the Department. Upon the subsequent sale, closure or transfer of the program, the Department may recover amounts that were paid as payment rate adjustments under this section. This recovery is determined through a review of actual costs and resident days in the receivership period. The costs the Department finds to be allowable are divided by the actual resident days for the receivership period. This rate is compared to the rate paid throughout the receivership period, with the difference multiplied by resident days, being the amount to be repaid to the Department. Allowable costs are determined by the Department as those ordinary, necessary, and related to resident care by prudent and cost-conscious management. The buyer or transferee shall repay this amount to the Department within 60 days after the Department notifies the buyer or transferee of the obligation to repay.

Section 8.110 **Receivership costs.** The Department may use the accounts and funds that would have been available for the room and board, services, and program costs of persons in the residential program for costs, cash flow, and accounting purposes related to the receivership.

SECTION 9.000 SPECIAL SITUATIONS.

Section 9.010 **Closure.** In order to facilitate an orderly transition of residents from community ICFs/DD to services provided under the home and community-based services waiver programs, upon closure of a facility, the facility’s contract is null and void.

Effective for services provided on or after September 1, 2017, a facility may request an interim payment rate based on historical fixed costs and estimated billable service days during the closure period. The Department will pay the interim rate during the closure period. Upon closure, the facility must submit data describing the actual fixed costs incurred by the facility during the closure period. The Department will then reconcile the interim payments to the actual fixed costs incurred. If total payments made to the facility exceed the actual fixed costs incurred, the facility must repay the excess to the Department. If total payments made to the facility are less than actual fixed costs incurred, the Department will make a final lump sum payment to the facility equal to the difference between the amount paid and the actual fixed costs incurred during the closure period.

Section 9.020 **Variable rate adjustments.** The following items apply for the payment rate adjustment.

A. A resident's county of financial responsibility requests a variable rate adjustment. The request must be for an amount not otherwise paid for through a facility's per diem.

The Department grants variable rate adjustments after considering:

(1) changes in a resident's condition(s);

(2) the typical cost to treat the condition(s), based on the community standard; and

(3) the facility's staffing levels.

B. Variable rate adjustments will not exceed $274.00 per day, per occurrence.

C. Variable rate adjustments remain in effect unless there is an identified change in need. A review of a resident's needs will occur once every year.

Variable rate adjustments may be approved when there is a documented increase in the needs of a resident due to the resident's full or partial permanent retirement from participation in a day training and habilitation program. The resident must:

(1) be at least age 65 or have a change in health condition that makes it difficult for the resident to participate in a day training and habilitation program over an extended period of time;

(2) express a desire for change through the developmental disability and related conditions screening process; and

(3) demonstrate increased need for staff assistance, changes in the type of staff credentials needed, or a need for expert consultation.

D. All facilities are eligible for a variable rate adjustment. Effective July 1, 2009 through June 30, 2010 variable rate adjustments in effect on June 30, 2009 are frozen and no new variable rate adjustments will be approved.

Section 9.030 **Relocation.**

A. For the initial rate year, property rates for facilities relocated after December 31, 1997, and up to and including October 1, 2000, have the full annual costs of relocation included in the initial rate year property rate. The property rate for the relocated facility is subject to the

costs that were allowable in the State plan in effect on September 30, 2000 and the investment per bed limitation for newly constructed or newly established class B facilities.

B. As of January 1, 2002, property rates for facilities relocated after October 1, 2000 may be adjusted.

(1) Relocated facilities are subject to the investment per bed limit for newly constructed or newly established class B facilities. The limits are adjusted on January 1 of each year by the percentage increase in the construction index published by the Bureau of Economic Analysis of the United States Department of Commerce in the Survey of Current Business Statistics in October of the previous two years. Facilities that are relocated within the investment per bed limit may be approved by the statewide advisory committee.

(2) Rate adjustments for facilities that relocate within the investment per bed limit are reviewed by the statewide advisory committee.

C. Costs for relocation exceeding the investment per bed limit are absorbed by the facility.

Section 9.040 **Disasters.**

A. Notwithstanding a provision to the contrary, effective June 6, 2003, a facility may receive payments for expenses specifically incurred due to a disaster. Payments will be based on actual documented costs for the period during which the costs were incurred, and will be paid as an add-on to the facility's payment rate, or as a lump sum payment. The actual costs paid will be reported on the next annual income and expense cost report as non-allowable costs, in order to avoid duplicate payment. Costs submitted for payments will be subject to review and approval by the Department. The Department's decision is final and not subject to appeal.

B. For transfers, the rates continue to apply for evacuated facilities, and residents are not counted as admissions to facilities that admit them.

Section 9.050 **Temporary adjustments for short-term admissions for crisis or specialized medical care.**

A. Effective July 1, 2003, the Department may designate up to 25 beds in facilities statewide for short-term admissions due to crisis care needs or care for medically fragile individuals. The Department may designate short-term beds based on the short-term care needs of a region or a county.

B. The Department will adjust the monthly facility rate to provide payment for vacancies in designated short-term beds by an amount equal to the rate for each recipient residing in a designated bed for up to 15 days per bed per month.

A claim is defined as those services billed on a single invoice (piece of paper) with the exception of Pharmacy and Long Term Care services. An adjustment or recovery submitted on an adjustment form is also regarded as a claim.

A Pharmacy claim is defined as the dispensing of one drug item for a recipient. More than one claim may be reported on a pharmacy invoice form (up to eight).

A Long Term Care claim is defined as the service provided to a recipient in a month by one Long Term Care facility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Requirements for Third party Liability
Identifying Liable Resources

(1) Frequency of Required Data Matches

Data matches are currently conducted with State Wage Information Collection Agencies (SWICAs) and SSA Wage and Earnings Files quarterly for recipients and non-custodial parents and monthly for new applicants.

A separate data match is not conducted with the state Title IV-A agency. Minnesota's organizational structure within the Department of Human Services (DHS) and local human service agencies eliminates the need for a data match to identify information maintained by the IV-A agency.

The data match with the Department of Labor and Industry for identification of potential workers' compensation benefits is conducted ~~bi-annually~~ monthly for current Medicaid eligibles. A match is conducted by the Office of Child Support Enforcement for non-custodial parents.

A data match with the Department of Public Safety, Driver and Vehicle Services Division motor vehicle accident report is conducted ~~at least bi-annually~~monthly for current Medicaid eligibles.

Follow-up Methods: Eligibility Processing or Data Matches

- Workers at the county agency are responsible for follow-up with employer regarding matches obtained through SWICA and SSA wage and earnings file data that are part of the eligibility process. In the course of following up on SWICNSSA wage and earnings file data, or in following up on determining a person's employment on an application or renewal or a report of a change in employment, workers would also determine if there is/was private health insurance available to the employee or family members through the employer. Workers enter the employer-based health coverage information they obtain through this process in the MMIS TPL Resource files for use in cost avoidance and post payment recovery.

- Workers at the county agency review responses on the application and renewal forms related to health insurance and other third party liability. Workers report all other potential sources of health coverage or liable third parties other than employer-sponsored insurance to the DHS TPL unit for follow-up using the Medical Service Questionnaire process (possible accident/injury).

- DHS and/or its contractor follow up on liable third party information received from data matches conducted with employers, insurers and other responsible entities, as required by the Deficit Reduction Act of 2005. DHS or its contractor obtain necessary files of insured persons and conduct matches to identify coverage in effect for Medicaid enrollees. Once verified information is obtained, the Department enters the information in the TPL subsystem of MMIS, and notifies the client's county worker of the entry of new TPL information.

- DHS follows up on TPL reports from county agency workers and data matches obtained for Medicaid clients from the Department of Labor and Industry and the Department of Public Safety. DHS sends the enrollee a Medical Service Questionnaire (MSQ) or Work Injury Report or Accident Injury Report for identification of injuries or accidents that may qualify for third party payment. The Department enters relevant data provided on the returned MSO into the TPL subsystem on MMIS. Adult enrollees receive two requests for information before receiving a termination notice for non-response (failure to cooperate) with MSQ requests.-A file is opened in the third party recovery unit at the point the Department identifies that:

  (1) there is a potential source of third party payment and

  (2) it has paid medical or subsistence benefits related to the injury,

  The time frame for incorporation of information into the third party liability case file and/or data base is two weeks from the date factors (1) and (2) are determined. The determination of these factors takes an average of 30 days from the date the completed form is received by DHS.

(2) Frequency of Diagnosis and Trauma Code Editing

Diagnosis and trauma code editing is done on-line on a daily basis. Claims are processed through the Medical Service Questionnaire processing on a two-week cycle.

An initial inquiry form requiring completion by the recipient is produced based on the diagnosis and trauma codes appearing on a medical claim.

Follow-up Methods: Diagnosis and Trauma Code

DHS follows up when medical bills indicate possible involvement in an accident.

DHS sends an MSO to an enrollee and reviews the completed form for probability of third party liability. Adult enrollees receive two requests for information before receiving a termination notice for non-response (failure to cooperate) with MSO requests. A file is opened in the third party recovery unit at the point the Department identifies that:

(1) there is a potential source of third party payment and

(2) it has paid medical or subsistence benefits related to the injury.

The time frame for incorporation of information into the third party liability case file and/or data base is two weeks from the date factors (1) and (2) are determined. The determination of these factors takes an average of 30 days from the date the completed form is received by the Department.

A program was developed to allow DHS to identify diagnosis codes with the highest recovery yields. The program is rm1 biannually and can be run on request.

STATE PLAN UNDER TITIE XIX OF THE SOCIAL SECURITY ACT

Requirements for Third Party Liability - Payment of Claims

(1) For cases active with the Department of Human Services Child Support Enforcement Division to establish paternity and obtain medical support and payment from, or derived from, the parents on behalf of a child:

The Department must pay the full amount of the claim and seek payment from liable third parties, if liability is derived from absent parents with obligations to pay medical support, and payment has not been made within 100 days. However, claims are cost avoided if one or more of the following conditions occur:

(a) No insurance paid amount is entered on the claim.
(b) No valid insurance denial reason code is entered on the claim.
(c) No documentation of non-payment is attached to the claim.

Documentation must include evidence that the claim was billed at least 30 days prior to the current submission and provider certification that no payment was received.

(2) Threshold amounts

Following is the threshold amount used to determine whether to seek recovery of payment from a liable third party:

Production of diagnosis and trauma follow-up - $100.00
Production of health insurance claims - $50.00

(3) Other guidelines for recovery

Following are the other guidelines used to determine whether to seek recovery of payment from a liable third party:

(a) Workers' compensation litigated cases are filed when medical and/or subsistence expenses are $500.00 or greater. This guideline reflects the additional case preparation time and legal counsel required for the intervention, settlement, and hearing processes. Claims under this dollar limit may be filed if the time limit on the Department's ability to file an intervention claim is nearing expiration and the nature of the injury suggests that additional expenses may be incurred.

cont. Requirements for Third Party Liability Payment of Claims

(b) Assigned automobile claims for minors or passengers in a vehicle driven by an uninsured person are filed when medical expenses are $200.00 or greater. This guideline reflects increased cost factors of case preparation. Health insurance claims are followed up to produce system-generated notices (1-3). Claims in excess of $500.00 will produce 4+ notices, until a closing or payment amount is entered.

(4) Determination of cost-effectiveness in seeking recovery from third parties

The Department considers a variety of cost and success factors on a case-by-case basis to determine whether (i) recovery of a claim is not cost-effective, or (ii) it is more cost-effective to pursue an amount less than the full cost of care. The factors considered include:

(A) an estimate of the cost of pursuing the claim, including attorney time required, travel and court fees, clerical and technical support expenses;

(B) the amount of the claim;

(C) factual and legal issues of liability as may exist between the Medicaid recipient and the liable party, including issues of causation and comparative fault;

(D) total funds available for settlement such as insurance policy limits or other factors relevant to the liable third party; and

(E) client involvement, such as cooperation or decision not to pursue the claim.

(5) In making the decision to seek recovery of payment, billings are accumulated by dollar amount. See number 2 above.

(6) Inpatient hospital coordination

Payment for inpatient hospital admission of patients who are simultaneously covered by medical assistance and a liable third party other than Medicare is the lesser of:

(a) the patient liability according to the provider/insurer agreement

cont. Requirements for Third Party Liability Payment of Claims

(b) Covered charges minus the third-party payment amount.

(c) The medical assistance rate established under this plan minus the third-party payment amount

A negative difference will not be implemented.

Medical assistance payment will not be made when either covered charges are paid in full by a third party or the provider has an agreement to accept payment for less than charges as payment in full.

(7) Payment by liable third parties: Medical Assistance eligibility or Medical Assistance benefits

Health insurers (including group health plans, HMOs and service benefit plans) must not take into account a recipient's medical assistance eligibility or a recipient's medical assistance benefits when enrolling the recipient or making any payments for benefits to the recipient or on the recipient's behalf.

Providers are required to bill liable third parties for services furnished under a long-term care insurance policy.

The state has in effect laws for the following:

(a) A responsible third party (other than providers of Medicare coverage under parts A, B, C or D) that requires prior authorization for an item or service must accept the state's authorization that the service is covered under the State plan (or waiver of such plan) for such individual, as if such authorization were the prior authorization made by the third party;

(b) A responsible third party (other than providers of Medicare coverage under parts A, B, C or D) must not deny a claim submitted by the State solely based on a failure to obtain prior authorization from the third party for an item or service; and

(c) A responsible third party must respond to any inquiry regarding a health care claim that is submitted not later than three years after the provision of such item or service to specify that the third party must respond within 60 days of receiving the inquiry.

(8) When processing claims for prenatal services, including labor and delivery and postpartum care, the Department uses standard coordination of benefits cost avoidance to reject, but not deny the claim when a third party is likely liable for the claim. If, after the provider bills the liable third party and a balance remains or the claim is denied payment for a substantive reason, the provider can submit a claim to the SMA for payment of the balance, up to the maximum Medicaid payment amount established for the service in the state plan.

(9) The Department makes payments without regard to third party liability for pediatric preventive services unless a determination has been made related to cost-effectiveness and access to care that warrants cost avoidance within 90 days.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Minnesota

1906 of the Act

State Method for Determining Cost-Effectiveness of Employer-Based Group Health Plans.

1. The following policies are considered cost-effective by the Benefit Recovery Section and do not require further review:

- Policies ~~with~~ for which the ~~a~~ monthly employer-based group health plan premium (or prorated portion of a family premium) ~~when added to the monthly pro-rated deductible~~ plus 1/12th of the annual average cost factor by age, is less than the current Minnesota Medical Assistance (MA) managed care monthly rate for ~~a~~ persons of the same age. See Examples of *Premium Calculation.*

  Annual average cost factor: This factor is the average paid costs of health insurance (deductible, coinsurance, and copayments) plus the cost of Medicaid wrap around benefits and administrative costs in a preceding calendar year, averaged by age group or pregnancy status for individuals with cost-effective coverage

  Birth up to age 1
  Age 1
  Age 2-15
  Age 16-20
  Age 21-49
  Age 21-49-Adults w/o Children
  Age 50-64
  Age 50-64-Adults w/o Children
  Age 65+
  Pregnant Women

The annual average cost factor will be adjusted on January 1 of each year.

When more than one individual is considered for cost-effective coverage under a single group health plan, the pro-rated premium and average annual costs by age for each individual will be added together and compared to the combined Medicaid managed care rate for the individuals.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Minnesota

- Policies where annual covered medical expenses exceed annual premium costs plus the annual average cost factor by at least a 2:1 ratio (review insurance payment reports or the EOMB to determine benefit versus cost) and the client's medical condition remains the same.

- ~~Policies covering people who have AIDS or who are HIV-positive when the premiums are not substantially increased due to the policy conversion.~~

- Long-term care (LTC) insurance policies covering nursing facility costs for residents when, at a minimum coverage includes the Medicare co-insurance for the current nursing facility stay. (Request the Benefit Recovery Section to review the policy at the end of 3 months.) The cost of an LTC policy is always less than cost of LTC services.

- ~~Policies covering a pregnant woman's maternity care, if the Premium Calculation is met by using the MA managed care monthly rate for a pregnant woman. Review the policy at the end of the 60-day postpartum period using the MA managed care rate by age category~~.

~~**EXAMPLE OF *PREMIUM CALCULATION*: Single Adult**~~

~~Employer health insurance monthly premium: $275.00~~
~~1/12th of Annual Deductible ($500): $ 42.00~~
~~$317.00~~

~~MA monthly capitation rate for Adult A (age 45): $286.00~~
~~**Not Cost Effective Under this CE Basis**~~
~~(Greater than Capitation by Age)~~

~~**EXAMPLE OF *PREMIUM CALCULATION*: Adult + Child**~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Minnesota

~~Employer health insurance monthly premium (2): $375.00~~
~~1/12th of the Annual Family Deductible ($500): 42.00~~
~~$417.00~~

~~MA monthly capitation rate for Adult A (age 45): $286.00~~
~~MA " " " " Child B (age 5): 214.00~~
~~$500.00~~

~~**Is Cost Effective Under this CE Basis**~~
~~(Less than Capitation by Age)~~

2. The following policies are not cost-effective and do not require Benefit Recovery Section review:

- Medicare Supplement or Medicare Advantage (Medicare Part C) policies or plans for clients age 65 and older.

- Hospital or long-term care indemnity policies that provide cash payments for each day in a hospital or nursing facility if the client is not currently collecting benefits.

3. The Benefit Recovery Section reviews all other policies for cost effectiveness. The county agency requests a cost effective review by ~~sending~~ faxing to the Benefit Recovery Section:

- ~~Three c~~ Copies of a completed DHS-2841a and b (with particular attention to current medical conditions; and.
- Available payment reports or Explanation of Medical Benefits (EOMB).

Administrative costs taken into account in accordance with 1906(e)(2) are inconsequential to determinations of cost-effectiveness.

State/Territory: MINNESOTA

Citation	Sanctions for Psychiatric Hospitals	
1902(y)(1), 1902(y)(2)(A), and Section 1902(y)(3) of the Act (P.L. 101-508, Section 4755(a)(2))	(a)	The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.
1902(y)(1)(A) of the Act	(b)	The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.
1902(y)(1)(B) of the Act	(c)	When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may: 1. terminate the hospital's participation under the State plan; or 2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or 3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.
1902(y)(2)(A) of the Act	(d)	When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

State/Territory: MINNESOTA

Citation	Sanctions for Managed Care Organizations
§1932(e) 42 CFR §438.726	(a) The State monitors for violations that involve the actions and failure to act specified in 42 CFR Part 438, Subpart I and to implement the sanctions provisions in 42 CFR Part 438, Subpart I, in the manner specified below: The Department requires the MCO to provide that the Department, CMS, or their agents have the right to evaluate through inspection or other means the quality, appropriateness, and timeliness of services or administrative procedures performed pursuant to the contract with the MCO. The Department may also monitor for violations through review of grievances and appeals, reports from the External Quality Review Organization, and through MCO self-reporting. If the Department or CMS finds that the quality of services offered by the MCO is materially deficient, the Department has the right to terminate the contract or to enforce one or more of the remedies pursuant to the contract. If the MCO fails substantially to provide medically necessary items and services that are required to be provided to an enrollee, or if the failure has adversely affected or has a substantial likelihood of adversely affecting the enrollee, the MCO is subject to one of the contractual remedies. The Department will give the MCO written notice of the violation prior to imposing a remedy and will allow the MCO an opportunity to cure within a time period that is commensurate with the violation. If the Department determines that the MCO failed to cure the violation within the specified time period, the State may enforce the one or more of the remedies as specified in the contract. (b) The State uses the definition below of the threshold that must be met before a MCO is considered to have repeatedly committed violations of §1903(m) and thus subject to imposition of temporary management: The Department will impose temporary management of the MCO upon a finding by the Department that the MCO has repeatedly failed to meet the substantive requirements of §§1903(m) or 1932, or has failed to attain and maintain financial stability in accordance with the fiscal requirements set forth by the Minnesota Department of Health. Factors that may be considered in imposing the sanction of temporary management are whether the behavior of the MCO is intentional or negligent; the substantial risk to enrollees' health; and/or the number of enrollees affected. (c) The State's contracts with MCOs provide that payment provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR §438.730(e).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State MINNESOTA

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

Note applicable: Minnesota does not provide income and eligibility verifications described in 42 CFR 435.948(a)(6). Minnesota complies with the mandatory IEVS matches.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

METHOD FOR ISSUANCE OF MEDICAL ELIGIBILITY CARDS TO HOMELESS INDIVIDUALS

Minnesota does not impose any residence requirement that excludes from the Medical Assistance program any otherwise eligible person who resides in the State, regardless of whether or not the residence is maintained permanently or at a fixed address. Persons who do not have a fixed residence are able to pick up the cards at the local county human service agency.

Medical assistance eligibility cards are issued upon determination of initial eligibility and replaced annually for those recipients who remain eligible. The card has a unique identifying number that medical providers use to contact the Electronic Verification System (EVS). Providers call EVS for eligibility information for each date on which service is provided.

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REQUIREMENTS FOR HEALTH CARE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives (in Minnesota, known as health care directives). If applicable, States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

HEALTH CARE DIRECTIVES: QUESTIONS AND ANSWERS ABOUT MINNESOTA LAW[1]

Minnesota law allows you to inform others of your health care wishes. You have the right to state your wishes or appoint an agent in writing so others know what you want if you can't tell them because of illness or injury. The information that follows tells about health care directives and how to prepare them. It does not give every detail of the law.

If you want more information about health care directives, please contact your health care provider, your attorney, ~~the Office of the Ombudsman for Older Minnesotans (1-800-657-3591 or 651-296-0382),~~ or ~~the University of~~ Minnesota ~~Extension Service (1-800-876-8636 or 612-624-4900), e-mail: order@dc.extension.umn.edu~~ Board on Aging's Senior LinkAge Line® 1-800-333- 2433. A suggested health care directive form is available on the internet at: http://www.mnaging.org/.

[1] Prepared by the Minnesota Department of Health, Division of Facility and Provider Compliance, in fulfillment of §1902(a)(58) of the Social Security Act, August 1998. This reflects reading level changes suggested by the Minnesota Department of Human Services, Health Care Administration.

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What is a health care directive?

A health care directive is a written document that informs others of your wishes about your health care. It allows you to name a person ("agent") to decide for you if you are unable to decide. It also allows you to name an agent if you want someone else to decide for you. You must be at least 18 years old to make a health care directive.

Why have a health care directive?

A health care directive is important if your attending physician determines you can't communicate your health care choices (because of physical or mental incapacity). It is also important if you wish to have someone else make your health care decisions. In some circumstances, your directive may state that you want someone other than an attending physician to decide when you cannot make your own decisions.

Must I have a health care directive? What happens if I don't have one?

You don't have to have a health care directive. But, writing one helps to make sure your wishes are followed.

You will still receive medical treatment if you don't have a written directive. Health care providers will listen to what people close to you say about your treatment preferences, but the best way to be sure your wishes are followed is to have a health care directive.

How do I make a health care directive?

There are forms for health care directives. You can get them from your health care provider; or attorney~~, or the Minnesota Board on Aging (1-800-882-6262 or 651-296-2770)~~. A suggested health care directive form is available on the internet at: http://www.mnaging.org/ (Minnesota Board of Aging).

You don't have to use a form, but your health care directive must meet the following **requirements** to be legal:

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- be in writing and dated.
- state your name.
- be signed by you or someone you authorize to sign for you, when you can understand and communicate your health care wishes.
- have your signature verified by a notary public or two witnesses.
- include the appointment of an agent to make health care decisions for you and/or instructions about the health care choices you wish to make.

Before you prepare or revise your directive, you should discuss your health care wishes with your doctor or other health care provider.

I prepared my directive in another state. Is it still good?

Health care directives prepared in other states are legal if they meet the requirements of the other state's laws or the Minnesota requirements. But requests for assisted suicide will not be followed.

What can I put in a health care directive?

You have many choices of what to put in your health care directive. For example, you may include:

- the person you trust as your agent to make health care decisions for you. You can name alternate agents in case the first agent is unavailable, or joint agents
- your goals, values and preferences about health care.
- the types of medical treatment you would want (or not want).
- how you want your agent or agents to decide.
- where you want to receive care.
- instructions about artificial nutrition and hydration.
- mental health treatments that use electroshock therapy or neuroleptic medications.
- instructions if you are pregnant.
- donation of organs, tissues and eyes.
- funeral arrangements.
- who you would like as your guardian or conservator if there is a court action.

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You may be as specific or as general as you wish. You can choose which issues or treatments to deal with in your health care directive.

Are there any limits to what I can put in my health care directive?

There are some limits about what you can put in your health care directive. For instance:

- your agent must be at least 18 years of age.
- your agent cannot be your health care provider, unless the health care provider is a family member or you give reasons for the naming of the agent in your directive.
- you cannot request health care treatment that is outside of reasonable medical practice.
- you cannot request assisted suicide.

How long does a health care directive last? Can I change it?

Your health care directive lasts until you change or cancel it. As long as the changes meet the health care directive requirements listed above, you may cancel your directive by any of the following:

- a written statement saying you want to cancel it.
- destroying it.
- telling at least two other people you want to cancel it.
- writing a new health care directive.

What if my health care provider refuses to follow my health care directive?

Your health care provider must follow your health care directive, or any instructions from your agent, as long as the health care follows reasonable medical practice. But, you or your agent cannot request treatment that will not help you or which the provider cannot provide.

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If the provider cannot follow your agent's directions about life-sustaining treatment, the provider must inform the agent. The provider must also document the notice in your medical record. The provider must allow the agent to arrange to transfer you to another provider who will follow the agent's directions.

What if I've already prepared a health care document? Is it still good?

Before August 1, 1998, Minnesota law provided for several other types of directives, including living wills, durable health care powers of attorney and mental health declarations.

The law changed so people can use one form for all their health care instructions.

Forms created before August 1, 1998, are still legal if they followed the law in effect when written. They are also legal if they meet the requirements of the new law (described above). You may want to review any existing documents to make sure they say what you want and meet all requirements.

What should I do with my health care directive after I have signed it?

You should inform others of your health care directive and give people copies of it. You may wish to inform family members, your health care agent or agents, and your health care providers that you have a health care directive. You should give them a copy. It's a good idea to review and update your directive as your needs change. Keep it in a safe place where it is easily found.

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

N/A

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

N/A

NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS

Social Security Act

§1919(e)(1)(A) The Department responsible for the initial approval of nurse aide training program curriculum and nurse aide competency evaluation programs is the Minnesota ~~Board of Nursing~~ Department of Health under contract to the Department of Human Services.

§1919(e)(1)(B) The Department responsible for the ongoing review and reapproval of nurse aide training program curriculum and nurse aide competency evaluation programs is the Minnesota ~~Board of Nursing~~ Department of Health under contract to the Department of Human Services.

Agencies involved in developing and administering nurse aide training and competency evaluation programs:

- Minnesota Department of Human Services
- Minnesota Department of Health
- ~~Minnesota Board of Nursing (MBN)~~
- Minnesota State Board of Vocational Technical Education
- ~~Interagency Board for Quality Assurance~~

~~Effective~~ As of January 1, 1989, ~~to receive State approval for a~~ nurse aide training and competency evaluation ~~program~~ programs or ~~a~~ nurse aide competency evaluation ~~program,~~ programs that met minimum program standards ~~must be met~~ received State approval. These standards are based on mandates of P.L. 100-203, the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), and on Minnesota law.

The Minnesota ~~Board of Nursing~~ Department of Health is charged with developing necessary standards to meet OBRA requirements, administering the initial competency evaluation program, and conducting the state reviews of compliance with program requirements. The Minnesota State Board of Vocational Technical Education is charged with developing necessary curricula to meet the requirements of this State plan attachment.

In 1989, the Minnesota Board of Nursing ~~will give~~ gave initial approval of nurse aide training programs ~~in 1989~~. Subsequent on-site reviews of programs ~~will be~~ are conducted by ~~MBN~~ the Minnesota Department of Health at least every two years. ~~During the interim year, programs will be required to submit documentation to MBN regarding program compliance.~~

Approval must be obtained prior to conducting a nurse aide training program. Programs will be approved or disapproved based upon their compliance with the standards established for programs offered in Minnesota. Nurse aide training and competency evaluation program standards are available to the public from ~~MBN~~ the Minnesota Department of Health and the Nurse Aide Registry. Training program curriculum developed by the Minnesota State College and University Board of Vocational Technical Education ~~will be~~ or the Minnesota Department of Health are available for purchase at a minimal fee.

There ~~will be~~ was a mandatory competency evaluation program for all nurse aides employed by a nursing facility as of July 1, 1989. Nurse aide training programs that were in existence and offered from January 1, 1989 until January 1, 1990 that ~~have~~ met State statutory requirements for approval and also ~~meet~~ met the Secretary's requirements for approval ~~will be~~ were deemed to have met necessary OBRA requirements. Individuals that ~~have~~ had completed such programs ~~may be~~ were deemed to have completed a training and competency evaluation program, and ~~will be~~ were included in the nurse aide registry. Those individuals employed as nurse aides in Minnesota who ~~have~~ did not ~~completed~~ complete an approved program ~~will be~~ were subject to the competency evaluation program ~~to be~~ conducted between July 1, 1989 and December 31, 1989.

As of October 1, 1990, nursing facilities must not use on a full time basis any individual as a nurse aide for more than four months unless the individual has successfully completed either a nurse aide training and competency evaluation program or a competency evaluation program approved by the Minnesota Department of Health. As of January 1, 1991, nursing facilities must not use on a temporary, per diem, leased, or on any other basis other than as a permanent employee, any individual as a nurse aide unless the individual successfully completed either a nurse aide training and competency evaluation program or a competency evaluation program approved by the Minnesota Department of Health.

~~MBN will hire~~ The Minnesota Department of Health ~~or contract with~~ approves community and technical colleges to provide sufficient qualified staff to conduct the initial competency evaluations. The Minnesota State College and University Board of Vocational Technical Education ~~will administer~~ administers competency evaluations for the ongoing facility-based training programs.

A standard test ~~will be~~ was used for the initial competency evaluation of currently employed nurse aides. ~~Ongoing competency evaluation programs may use a similar test or the State may develop a competency evaluation with Minnesota-specific questions.~~ The Department contracts with Assessment Systems, Inc. (ASI), which develops, scores, and reports the results of the competency examination to the Minnesota Nursing Assistant Registry, maintained by the Minnesota Department of Health.

Nurse aides need not pass the written/oral component before taking the skills component of the competency evaluation. Nurse aides who do not successfully complete the competency evaluation will be allowed two additional opportunities to successfully complete it.

NURSE AIDE REGISTRY

Social Security Act §1919(e)(2)

The Department responsible for the establishment and maintenance of a registry of trained and competent nurse aides is the Minnesota ~~Board of Nursing (MBN)~~ Department of Health, the State survey agency, under contract to the Minnesota Department of Human Services (the single State agency) ~~and the Minnesota Department of Health (the State survey agency)~~.

Prior to 1992, the Minnesota Board of Nursing developed and maintained the nurse aide registry. ~~Effective~~ Since January 1, ~~1989~~ 1992, the ~~MBN will develop~~ Minnesota Department of Health has developed and ~~maintain~~ maintained ~~a nursing assistant~~ the nurse aide registry of individuals employed in skilled nursing facilities and nursing facilities who have successfully completed a state approved nursing assistant training and competency evaluation program of a minimum of 75 hours or a nursing assistant competency evaluation program. The registry ~~will~~ also ~~identify~~ identifies nursing assistants who have successfully completed a retraining program. Information on the registry ~~will be~~ is available to the public.

~~Currently employed nursing assistants~~ Nurse aides, working ~~(~~as of June 30, 1989~~)~~, ~~will be~~ were required to successfully complete a ~~nursing assistant~~ nurse aide competency evaluation program between July 1, 1989 and December 31, 1989 to be included in the registry. ~~Beginning~~ As of July 1, 1989, newly employed ~~nursing assistants~~ nurse aides must successfully complete a state approved nursing assistant training and competency evaluation program of at least 75 hours to be included in the registry.

~~After January 1, 1990,~~ A nursing facility must not employ an individual as a ~~nursing assistant~~ nurse aide unless the facility has inquired of the ~~MBN registry~~ Minnesota Department of Health and the Nurse Aide Registry as to the information in the registry concerning that individual.

Pursuant to 42 CFR §483.156(c), the following items ~~will be~~ are the minimum information maintained in and retrievable from the nurse aide registry for each individual listed ~~there~~:

- current full name and address at the time the competency evaluation was conducted;
- date of birth;
- Social Security Number and any other information necessary to identify each individual;

- ~~SNF or NF where employed or most recent date and place of employment; and~~
- name and address of approved training and competency evaluation program and date successfully completed; and
- substantiated findings of abuse, neglect, or misappropriation of resident property.

The above data will be reported to the registry within ~~60~~ 30 days of successful completion of the training and competency evaluation program or competency evaluation program.

Additional data that is requested of people applying for the nursing assistant registry is found in Attachment 4.38-A.

Nursing assistants will be responsible for informing the registry of any changes in their:

- name;
- address; and
- place of employment.

An individual on the registry who has not performed nursing or nursing-related services for at least eight hours for monetary compensation for a continuous 24-month period after completion of a training and competency evaluation program; is removed from the registry (exception: an individual found to have abused or neglected residents or misappropriated resident property) and must complete a new training and competency evaluation program in order to ~~remain in~~ be placed back on the registry.

~~Beginning~~ Since October 1, 1990, the registry ~~will~~ also ~~contain information addressing the substantiated findings of any State investigations concerning resident abuse or neglect or misappropriation of resident property by a nursing assistant or any other individual employed in a nursing facility, and~~ contains a brief statement (if any) by the individual disputing the findings. In the case of inquiries to the registry concerning an individual listed in the registry, the information disclosed must also include a clear and accurate summary of the finding of resident abuse/neglect or misappropriation of resident property. Findings of resident abuse or neglect or misappropriation of resident property are included in the registry within ten working days and must remain there permanently, unless the finding was made in error, the individual was found not guilty in a court of law, the State is notified of the individual's death, or, in the case of neglect, the individual successfully petitioned the Minnesota Department of Health (see Attachment 4.40-B). Only the Minnesota Department of Health, based on the documented findings, ~~will place the individual's name~~ places information concerning substantiated allegations in the registry ~~concerning the substantiated allegation~~.

Allegations of resident neglect, abuse, or misappropriation of resident property ~~will be~~ are investigated by the Minnesota Department of Health. No record of the allegation ~~will be~~ is added to the registry until the incident has been investigated, the individual has been accorded a hearing and the allegations have been substantiated; or the individual has waived ~~their~~ his/her right to a hearing.

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COLLECTION OF ADDITIONAL REGISTRY INFORMATION

The following additional data is requested of people applying for the ~~nursing assistant~~ nurse aide registry in Minnesota:

1. ~~Race/ethnic information. Disclosure of this information by the applicant is optional and is used for statistical purposes only.~~

2. ~~The name of the training site and its location (i.e., city and state).~~

3. ~~The name of the competency evaluation (i.e., testing) site and its location.~~

4. ~~The applicant's full name at the time of testing.~~

5. ~~The applicant's address at the time of testing.~~

6. ~~The full name and the signature of the testing evaluator in order to verify that the applicant passed the competency evaluation.~~

~~7.~~ the name of the applicant's employer if a nursing facility, temporary agency or home health agency.

~~8.~~ 2. The employment start date for Item ~~7~~ 1.

~~9.~~ 3. The full name and signature of the nursing facility administrator or director of nursing listed in item ~~7~~ 5 in order to verify the employment of the applicant.

~~10.~~ 4. The signature of the applicant, certifying that all information provided is true and correct.

~~11.~~ 5. The date the application is completed.

~~All~~ Specific information requested of applicants to the ~~Nursing Assistant~~ Nurse Aide Registry ~~in Minnesota~~ is public information and can be disclosed to anyone who requests the information. ~~Applicants are informed of this on the application form by the following notification: "The data supplied become part of your permanent file which is a public record."~~ In Minnesota, an applicant's name is considered public information.

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State/Territory: Minnesota

DEFINITION OF SPECIALIZED SERVICES

For People with Mental Retardation and Related Conditions:

A continuous program for each client with mental retardation or related conditions which includes aggressive, consistent implementation of a program of specialized and generic training, specific therapies or treatments, activities, health services and related services, as identified in an individualized plan of care. The individual program plan must be developed and supervised by an interdisciplinary team that represents areas relevant to identifying the client's needs and to designing programs that meet the client's needs.

For People with Mental Illness:

A continuous and aggressive individualized plan of care developed by an interdisciplinary team of qualified mental health professionals, including the attending physician, and that prescribes specific therapies and activities for the treatment of acute episodes of mental illness, and/or is designed to reduce behavioral symptoms and to improve the level of independent functioning with the goal of reducing the intensity of mental health services.

Minnesota believes that these services can be provided across the continuum of mental health community-based and institutional settings. Because we have chosen to individualize each person's needs for specialized services, Minnesota has chosen not to develop a specific list of services. However, examples of specialized services include, but are not limited to, specialized day treatment, vocational rehabilitation, community support, independent living skills assessments and programming, intensive case management, enhanced housing support, crisis/emergency services, enhanced individualized programming in residential treatment settings and inpatient psychiatric treatment.

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CATEGORICAL DETERMINATIONS

For People with Mental Retardation and Related Conditions:

Advance group determinations for nursing facility (NF) care can be made for an individual in the following categories if the person:

a) Requires convalescent care for an acute physical illness for which hospitalization was required within the past two weeks. Convalescent care in a NF is limited to 120 days.

b) Has a terminal illness. There must be a signed statement from a physician stating that the person's medical prognosis is that his or her life expectancy is six months or less.

c) Has a severe physical illness, such as, but not limited to:

1) coma;
2) ventilator dependence;
3) functioning at a brain stem level;
4) chronic obstructive pulmonary disease;
5) Parkinson's disease;
6) Huntington's disease;
7) amyotrophic lateral sclerosis; or
8) congestive heart failure.

The severe illness must result in a level of impairment so severe that, in the judgment of a qualified mental retardation professional, and based on the individualized evaluation and determination regarding the need for specialized services, the person could not be expected to benefit from active treatment.

d) Has delirium, and an accurate diagnosis can not be made until the delirium clears. The applicant may be provisionally admitted. It is the responsibility of the NF to immediately notify the Local Mental Retardation Authority in its county when the delirium clears in order for an individualized evaluation to occur and determinations to be made concerning the need for NF care and specialized services. The Level II evaluation and determinations must be completed within

For People with Mental Retardation and Related Conditions:
(continued.)

seven working days of the referral to the Local Mental Retardation Authority.

e) Needs a brief and time-limited stay to provide respite to in-home caregivers to whom the person with mental retardation is expected to return following the brief NF stay. A stay is limited to persons who require some type of medical intervention that the NF is capable of providing. Each stay is limited to a maximum of 30 days in any 12-month period, and must be approved by the Department's Division for Persons with Developmental Disabilities. Respite care in a nursing facility will be approved only if more appropriate services (e.g. foster care with community-based health services) are unavailable. The case manager must document to the Department's Division for Persons with Developmental Disabilities which alternatives were considered and why they were rejected.

f) Needs a brief and time-limited stay of not more than seven days in emergencies requiring protective services. If a longer stay is anticipated, a complete Level II assessment to determine the need for nursing facility and specialized services must be completed by the Local Mental Retardation Authority within seven days of admission.

For People with Mental Illness:

Advance group determinations of the need for NF care can be made for an individual in the following categories if the person:

a) Has recently been admitted to an acute care hospital, is being admitted to a NF for the same reason the individual was hospitalized, and the attending physician confirms in writing that the individual likely will not require more than 30 days of NF care.

b) Has a terminal illness for which the physician has indicated in writing that the individual's medical prognosis of life expectancy is six months or less.

c) Has the following physical conditions and/or diagnoses with physical limitations of such severity that admission to or residence in a NF is normally needed:

For People with Mental Illness: (continued.)

1) coma;
2) ventilator dependent;
3) functioning at the brain stem level;
4) acute cardio-vascular accident that presents with emotional sequela and/or aphasia; or
5) advanced conditions of chronic obstructive pulmonary disease, congestive heart failure, Parkinson's Disease, amyotropic lateral sclerosis (ALS) or Huntington's Chorea.

d) Has delirium, and an accurate diagnosis can not be made until the delirium clears. The applicant may be provisionally admitted. It is the responsibility of the NF to immediately notify the Local Mental Health Authority in its county when the delirium clears in order for an individualized evaluation to occur and determinations to be made concerning the need for NF care and specialized services. The Level II evaluation and determinations must be completed within seven working days of the referral to the Local Mental Health Authority.

e) Has need of brief stays (not to exceed 30 days per calendar year) to provide respite care for in-home caregivers to whom the individual with mental illness is expected to return. The applicant must need the level of care provided by the NF. The Local Mental Health Authority must verbally approve the admission and specify the amount of time approved for each stay.

f) Is in an emergency situation and requires 24 hour protective services. A Level II evaluation must be completed within seven days from the date of admission. It is the responsibility of the NF to contact the Local Mental Health Authority in its respective county to schedule the Level II evaluation.

Emergencies are defined as situations in which the individual is in a harmful environment or a caregiver is suddenly incapacitated, and the individual cannot provide for his or her own care.

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures and policies.

The Minnesota Department of Health, the State survey and certification agency, fulfills this requirement by:

1) Issuing a quarterly newsletter, *The Resource*, to all nursing facilities, and nursing home organizations and resident councils, which updates them on changes in the survey process and on new requirements;

2) Issuing Informational Bulletins to facilities to transmit or clarify information;

3) Conducting training sessions; and

4) Speaking to industry and consumer groups on survey issues upon request and based on staff availability.

The State of Minnesota also appropriates money to support a statewide education and support program for resident and family councils. These councils are mandated by State law.

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

Allegations of neglect, abuse and misappropriation of property are reported to the Minnesota Office of Health Facility Complaints. The Office's staff investigate allegations through on-site visits and interviews with residents, family and staff to make ~~a determination~~ determinations.

If ~~the allegation~~ allegations are substantiated, Minnesota ~~state~~ law sets forth a procedure to permit the ~~nursing assistant~~ nurse aide to appeal the determination. The ~~nursing assistant~~ nurse aide is notified of the determination by certified mail and has 30 days to file an appeal. If an appeal is filed, a hearing is conducted by ~~the Minnesota Office~~ a Department of ~~Administrative Hearings~~ Human Services appeals referee. ~~The hearing must be held within 60 days of the appeal.~~ The ~~Office of Administrative Hearings~~ appeals referee issues a report to the commissioner of Health, who makes the final determination. A copy of the determination is mailed to the ~~nursing assistant~~ nurse aide. If the Department's findings of abuse, neglect or misappropriation of property are upheld, ~~notice~~ this information is ~~given to~~ placed in the ~~Nursing Assistant~~ Nurse Aide Registry.

If the ~~nursing assistant~~ nurse aide chooses not to appeal the department's findings, the ~~Nursing Assistant~~ Nurse Aide Registry is notified immediately.

Pursuant to §1919(g)(1)(D) of the Act, if there is a finding of neglect, the Department must permit the nurse aide to petition to have his or her name removed from the Nurse Aide Registry upon a Department determination that the employment and personal history of the individual does not reflect a pattern of abusive behavior or neglect, and the neglect involved in the original finding was a singular occurrence. However, such a determination may not be made before the expiration of the one-year period beginning on the date on which the name of the individual was added to the Nurse Aide Registry due to neglect, abuse or misappropriation of resident property.

OMB No.:

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

The Minnesota Department of Health follows all requirements of the Health Care Financing Administration in conducting unannounced surveys, within required timeframes. The Department carefully guards survey schedule information and limits the number of people who have access to the information. The Department coordinates with its subcontractor for fire safety inspections to ensure that the subcontractor does not arrive at a facility before the survey team.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

To measure and reduce inconsistencies in the survey process, the Minnesota Department of Health conducts an annual face-to-face inservice training session for staff and provides additional inservices through videoconferencing to educate staff about changes in the survey process or changes in regulations. The number of inservice sessions is based upon budget and workload constraints.

Samples of deficiencies are reviewed by the survey and review supervisor, assistant program manager and program manager before being sent to the facility. Monthly supervisor staff meetings assure ample opportunities to share and compare survey results and provide needed clarification.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: MINNESOTA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors, on-site, on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

The Office of Health Facility Complaints, located in the State survey and certification agency, is responsible to investigating complaints. The Office utilizes protocols established by the Health Care Financing Administration to conduct its investigations.

Facilities are monitored by follow-up visits to verify correction of deficiencies. Facilities with a poor compliance history are monitored on a regular basis by the use of randomly scheduled visits to ensure continued compliance.

Citation — Employee Education About False Claims Recoveries: State Compliance Oversight

§1902(a)(68)
P.L. 109-171

The Provider Agreement requires that providers agree, as a condition of participation in the Medicaid program, to comply with all federal and state statutes and rules. The provider agreement is signed by all providers, including managed care organizations and all other entities to whom section 1902(a)(68) applies. All providers are informed that failure to comply risks their participation in the Medicaid program.

Effective May 18, 2007, the provider agreement will be revised to specifically require compliance with section 1902(a)(68) of the Social Security Act. New and re-enrolling providers will be required to sign the revised provider agreement.

On January 22, 2007, the state notified all providers, including all entities subject to requirements of section 1902(a)(68) of the Social Security Act, of the requirements of section 1902(a)(68).

Beginning June 1, 2007, when the state conducts routine or random onsite visits of an entity subject to the requirements of section 1902(a)(68) of the Social Security Act, it will assess for compliance with section 1902(a)(68) of the Act. The state has the authority to impose sanctions, including disenrollment, for failure to comply with the provisions of Title XIX.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Minnesota

Citation	
1902(a)(69) of the Act, (section 6034) P.L. 109-171	4.43 Cooperation with Medicaid Integrity Program Efforts. The Medicaid agency assures it complies with the Medicaid Integrity Program established under section 1936 of the Act, and that it will comply with any requirements of the Medicaid Integrity Program issued by the Secretary in accordance with the law.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

SECTION 5 PERSONNEL ADMINISTRATION

Citation
42 CFR 432.10(a)
AT-78-90
AT-79-23
AT-80-34

5.1 Standards of Personnel Administration

(a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

/XX The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

5.2 [Reserved]

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

Citation		
42 CFR Part 432, Subpart B AT-78-90	5.3	Training Programs; Subprofessional and Volunteer Programs The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers.

TN # 78-4
Supersedes
TN #

Approval Date 5-5-78 Effective Date 1-1-78

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MINNESOTA

SECTION 6 FINANCIAL ADMINISTRATION

Citation

6.1 Fiscal Policies and Accountability

42 CFR 433.32
AT-79-29

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.

Federal Matching of Y2K-Related State Projected Payments to Medicaid and State Children's Health Insurance Program (SCHIP) Providers

Given the uniqueness of the Y2K problem and the desire to avoid disruptions of services to beneficiaries, while also ensuring the ongoing fiscal integrity of the Medicaid and SCHIP programs, HCFA will provide FFP in States' payments based on projected provider claims made in accordance with all of the following terms and conditions during the period January 1, 2000 through March 31, 2000 that are a direct result of State Y2K claims processing problems.

1. FFP is available for payments made to Medicaid and SCHIP providers based on projected provider claims during the period January 1, 2000 through March 31, 2000 that are the direct result of **State** Y2K claims processing problems. If at any time before March 31, 2000 the State's claims processing system becomes Y2K compliant, FFP will no longer be available for any projected payments made after the date the State's claims processing systems becomes Y2K compliant.

2. The project provider claims for which FFP will be available will be computed by the State as the average of the last 12 months of payments to each provider, or of the period specified in the State's Y2K Contingency Plan. For Managed Care Organizations (MCOs) the State may use the previous month's payment (i.e. December 1999).

3. Once the State determines the average monthly payment to the provider, HCFA will allow the State to claim FFP for their projected payments up to 70 percent of the average monthly payment for institutional providers and capitated MCOs, and up to 50 percent of the average monthly payment for non-institutional providers.

State MINNESOTA

Citation

4. The State must establish an accounts receivable for all payments made and for which FFP was claimed based on projected provider claims.

5. When the period for which FFP is available for payments based on projected provider claims ends, the State must incorporate into its claims processing system an edit check designed to preclude duplicate payments to providers where payments based on projected provider claims were made and have not yet been fully reconciled.

6. By no later than **April 1, 2000**, for each provider, the State must begin reconciling payment made based on projected provider claims accounts receivable balances for the January 1 - March 31, 2000 period against 100 percent of each provider's adjudicated claim amounts for that same period, and begin recouping any excessive payments that were made to a provider based on projected provider claims amounts. All overpayments that were made based on projected provider claims must be either recovered or returned as overpayments by **September 30, 2000.** No FFP will be available for extended repayment schedules for providers.

7. Before implementing this projected provider claims payment process, the State must purge its files of all excluded providers to preclude any payments to excluded providers.

8. Once the State has completed the final reconciliation of all accounts receivable balances, and it has been reviewed by the RO, the State must report the Federal share of any outstanding State overpayments to HCFA on the next Form HCFA-64. Any outstanding overpayments that have not been reported on the Form HCFA-64 for the quarter ended September 20, 2000 will be disallowed.

State MINNESOTA

Citation 6.1 Fiscal Policies and Accountability

9. The State agrees that this policy applies only to payments based on projected provider claims made because **State** Y2K claims processing problems preclude the State from processing and paying provider claims in accordance with normal program claiming requirements. It does **not** apply to payments made because of Y2K problems which preclude providers from billing the State, or because of problems not related to State Y2K claims processing problems. State payments based on projected provider claims that are not in accordance with all of the terms and conditions of this State plan amendment will be disallowed.

10. Before implementation, the State must submit to the Regional Office for approval, along with this state plan amendment, the State's plan for specifically implementing the terms and conditions of this State plan amendment.

Federal Matching of Ambulatory Payment Classification (APC) System Payments to Medicaid Outpatient Hospital Facility Providers

Given the desire to avoid disruptions of services to recipients, while also ensuring the ongoing fiscal integrity of the Medicaid program, HCFA will provide FFP in Minnesota's interim payments based on projected provider claims made in accordance with all of the following terms and conditions during the period August 1, 2000 through April 30, 2001 that are a direct result of State claims processing issues.

1. FFP is available for bimonthly interim payments based on projected provider claims during the period August 1, 2000 through April 30, 2001, that are the direct result of State claims processing issues. If the State's claims processing system processes APC claims before April 30, 2001, FFP will no longer be available for any projected payments made after the date the State's claims processing system processes APC claims.

2. The projected provider claims for which FFP will be available are computed by the State as the average payment to providers that received an average of at least $2000 on each paid warrant claim for the period November 1, 1999 through April 30, 2000.

State MINNESOTA

Citation 6.1 Fiscal Policies and Accountability

A. Providers that received an average of at least $2000 on each paid warrant claim for this time period were offered interim payments. All providers in this group chose to receive interim payments.

B. Providers that received an average less than $2000 on each paid warrant claim for this time period were given the opportunity to request interim payments. No providers in this group chose to receive interim payments.

3. Once the State determines the bimonthly interim payment to the provider, HCFA will allow the State to claim FFP for the projected payments.

4. The State is making and tracking payments within its MMIS system for which FFP was claimed based on projected provider claims.

5. When the period for which FFP is available for bimonthly interim payments based on projected provider claims ends, the State must incorporate into its claims processing system an edit check designed to preclude duplicate payments to providers where payments based on projected provider claims were made and have not yet been fully reconciled.

6. By no later than May 1, 2001, for each provider, the State must begin reconciling payment made based on projected provider claims accounts receivable balances for the August 1, 2000 - April 30, 2001 period against a three-month average warrant paid during that same period. Out of all paid claims, any amount over the established three-month average warrant paid will be applied to the credit/recoupment balance owing. All overpayments that were made based on projected provider claims must be returned as overpayments **by March 31, 2002.** No FFP will be available for extended repayment schedules for providers.

7. Before implementing this interim payment process, the State must purge its files of all excluded providers to preclude any payments to excluded providers.

State MINNESOTA

Citation 6.1 Fiscal Policies and Accountability

8. Once the State has completed the final reconciliation of all accounts receivable balances, the State must report the Federal share of any outstanding State overpayments to HCFA on the next Form HCFA-64. **Any outstanding overpayments that have not been reported on the Form HCFA-64 for the quarter ending March 31, 2002 will be disallowed.**

9. The State agrees that this policy applies only to payments based on projected provider claims made because temporary State claims processing issues preclude the State from processing and paying provider claims in accordance with the APC system. It does not apply to payments made because of problems that preclude providers from billing the State, or because of issues not related to State claims processing issues. State payments based on projected provider claims that are not in accordance with all of the terms and conditions of this State plan amendment will be disallowed.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: MINNESOTA

Citation		
42 CFR 433.34 ~~(b)~~ AT-79-29	6.2	Cost Allocation The Medicaid agency meets the requirements of 42 CFR 433.34~~, paragraphs (c) through (e)~~ with respect to the submittal and content of a cost allocation plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: MINNESOTA

Citation
42 CFR 433.53
AT-79-29
AT-80-34

6.3 State Financial Participation

(a) State funds are used in both assistance and administration.

☐ State funds are used to pay all of the non-Federal share of total expenditures under the plan.

☒ There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level or administration under the plan in any part of the State.

(b) State and federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

42 CFR 433.10(c)(2)
1905(b)

(c) For services provided on or after July 11, 1996, the federal share of State expenditures for services provided through:

(1) Indian Health Services (IHS) facilities; or

(2) facilities owned or operated by a tribe or tribal organization and funded by Title I or III of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, operating as 638 facilities, is 100 percent.

Services provided at or through a 638 or IHS facility include any service covered under Attachment 3.1-A or 3.1-B provided to any recipient eligible under the plan on the premises of the facility or provided by a health provider employed by the facility who travels to the patient. 100% federal match will be claimed for services provided through an IHS or 638 facility to any Medicaid eligible person who received any covered Medicaid service provided through an IHS or 638 facility during the calendar year.

Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
August 1991

State/Territory: MINNESOTA

SECTION 7 - GENERAL PROVISIONS

Citation	7.1 Plan Amendments
42 CFR 430.12(c)	The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
August 1991

State/Territory: MINNESOTA

Citation

7.2 Nondiscrimination

45 CFR Parts 80 and 84

In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap.

The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A.

next page is 89;
p. 88 deleted per
TN 93-26

Revision: HCFA-91-4 (FPD)
August 1991

OMB No. 0938-

State: MINNESOTA

Citation

7.4 State Governor's Review

42 CFR §430.12(b)

The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Centers for Medicare & Medicaid Services with such documents.

x Not applicable. The Governor:

___ Does not wish to review any plan material.

___ Wishes to review only the plan materials specified in the enclosed document.

x The Governor's designee is the head of the Medicaid agency.

I hereby certify that I am authorized to submit this plan on behalf of the MINNESOTA DEPARTMENT OF HUMAN SERVICES.
(Designated Single State Agency)

Date: 7/26/10

Medicaid Director
Health Care Administration

NON-DISCRIMINATION COMPLIANCE

The Department's Provider Agreement contains a provision that Medicaid providers agree, as a condition of participation in the Medicaid program, to:

> Comply with all federal statutes, implementing regulations and guidance prohibiting discrimination on the basis of race, color, national origin, sex, age, religion and disability in any program or activity receiving federal financial assistance from the U.S. Department of Health and Human Services; and to comply with the Minnesota Human Rights Act.

Referrals of allegations of discrimination are referred to the Minnesota Department of Human Rights for investigation and enforcement actions. Providers determined to be in violation of the non-discrimination language of the Provider Agreement are subject to various sanctions including fines, restraining orders, and punitive damages.

Vaccine and Vaccine Administration at Section 1905(a)(4)(E) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage

__X__ The state assures coverage of COVID-19 vaccines and administration of the vaccines.[1]

__X__ The state assures that such coverage:

1. Is provided to all eligibility groups covered by the state, including the optional Individuals Eligible for Family Planning Services, Individuals with Tuberculosis, and COVID-19 groups if applicable, with the exception of the Medicare Savings Program groups and the COBRA Continuation Coverage group for which medical assistance consists only of payment of premiums; and
2. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(H) and section 1916A(b)(3)(B)(xii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

__X__ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing or similar charge, pursuant to section 1937(b)(8)(A) of the Act.

_X_The state provides coverage for any medically necessary COVID-19 vaccine counseling for children under the age of 21 pursuant to §§1902(a)(11), 1902(a)(43), and 1905(hh) of the Act.

_X__ The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration, with respect to the providers that are considered qualified to prescribe, dispense, administer, deliver and/or distribute COVID-19 vaccines.

Additional Information (Optional):

[1] The vaccine will be claimed under this benefit once the federal government discontinues purchasing the vaccine.

Reimbursement

_X__ The state assures that the state plan has established rates for COVID-19 vaccines and the administration of the vaccines for all qualified providers pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

List Medicaid state plan references to payment methodologies that describe the rates for COVID-19 vaccines and their administration for each applicable Medicaid benefit:

The Medicare rate for COVID-19 administration of vaccines was adopted in the Medicaid State Plan under Disaster Relief SPA 21- 09: where vaccine administration is separately reimbursable at the fee schedule rate, payment for administration of COVID-19 vaccinations is made at the rates established by Medicare in effect at the time the service is provided; COVID-19 vaccine administration will be paid at 100% of the geographically adjusted (GCPI) Medicare equivalent rates. The Medicare rate for COVID-19 vaccines, separately administered, was adopted under Disaster Relief SPA 21-13: the rate is at 100% of the geographically adjusted (GCPI) Medicare equivalent rates.

___ The state is establishing rates for COVID-19 vaccines and the administration of the vaccines pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

____ The state's rates for COVID-19 vaccines and the administration of the vaccines are consistent with Medicare rates for COVID-19 vaccines and the administration of the vaccines, including any future Medicare updates at the:

____ Medicare national average, OR
____ Associated geographically adjusted rate.

____ The state is establishing a state specific fee schedule for COVID-19 vaccines and the administration of the vaccines pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

The state's rate is as follows and the state's fee schedule is published in the following location:

____ The state's fee schedule is the same for all governmental and private providers.

____ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 vaccines and the administration of the vaccines are described under the benefit payment methodology applicable to the provider type:

____The payment methodologies for COVID-19 vaccines and the administration of the vaccines for providers listed above are described below:

___The state is establishing rates for any medically necessary COVID-19 vaccine counseling for children under the age of 21 pursuant to sections 1905(a)(4)(E), 1905(r)(1)(B)(v) and 1902(a)(30)(A) of the Act.

___The state's rate is as follows and the state's fee schedule is published in the following location:

PRA Disclosure Statement: *Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

COVID-19 Testing at section 1905(a)(4)(F) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage

_X__ The states assures coverage of COVID-19 testing consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.

_X__ The state assures that such coverage:

1. Includes all types of FDA authorized COVID-19 tests;
2. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
3. Is provided to the optional COVID-19 group if applicable; and
4. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

Please describe any limits on amount, duration or scope of COVID-19 testing consistent with 42 CFR 440.230(b).

_X__ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

_X__The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Reimbursement

__X__ The state assures that it has established state plan rates for COVID-19 testing consistent with the CDC definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.

List references to Medicaid state plan payment methodologies that describe the rates for COVID-19 testing for each applicable Medicaid benefit:

The state pays the rate as described in Attachment 4.19-B of the Medicaid State Plan, item 3, Other Laboratory and X-ray Services.

____ The state is establishing rates for COVID-19 testing pursuant to pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

____ The state's rates for COVID-19 testing are consistent with Medicare rates for testing, including any future Medicare updates at the:

____ Medicare national average, OR

____ Associated geographically adjusted rate.

____ The state is establishing a state specific fee schedule for COVID-19 testing pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

The state's rate is as follows and the state's fee schedule is published in the following location :

____ The state's fee schedule is the same for all governmental and private providers.

____ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 testing is described under the benefit payment methodology applicable to the provider type:

Additional Information (Optional):

____The payment methodologies for COVID-19 testing for providers listed above are described below:

PRA Disclosure Statement *Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

COVID-19 Treatment at section 1905(a)(4)(F) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage for the Treatment and Prevention of COVID

_X_ The states assures coverage of COVID-19 treatment, including specialized equipment and therapies (including preventive therapies).

_X_ The state assures that such coverage:

1. Includes any non-pharmacological item or service described in section 1905(a) of the Act, that is medically necessary for treatment of COVID-19;
2. Includes any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations;
3. Is provided without amount, duration or scope limitations that would otherwise apply when covered for purposes other than treatment or prevention of COVID-19;
4. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
5. Is provided to the optional COVID-19 group, if applicable; and
6. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

_X_ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

_X_ The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Coverage for a Condition that May Seriously Complicate the Treatment of COVID

_X_ The states assures coverage of treatment for a condition that may seriously complicate the treatment of COVID-19 during the period when a beneficiary is diagnosed with or is presumed to have COVID-19.

_X_ The state assures that such coverage:

1. Includes items and services, including drugs, that were covered by the state as of March 11, 2021;
2. Is provided without amount, duration or scope limitations that would otherwise apply when covered for other purposes;
3. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
4. Is provided to the optional COVID-19 group, if applicable; and
5. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(l) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

_X__ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

_X_ The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Reimbursement

_X__ The state assures that it has established state plan rates for COVID-19 treatment, including specialized equipment and therapies (including preventive therapies).

All COVID-19 treatments are within the services as described in attachments 3.1-A and 3.1-B; payment rates for those services are found in Attachment 4.19-B.

List references to Medicaid state plan payment methodologies that describe the rates for COVID-19 treatment for each applicable Medicaid benefit:

Attachment 7.7-C
Page 3

____ The state is establishing rates or fee schedule for COVID-19 treatment, including specialized equipment and therapies (including preventive therapies) pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

____ The state's rates or fee schedule is the same for all governmental and private providers.

____ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 vaccines and the administration of the vaccines are described under the benefit payment methodology applicable to the provider type:

Additional Information (Optional):

PRA Disclosure Statement *Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*