

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

Our File No. 1094

RULE REVIEW CHECKLIST

DATE RULE RECEIVED 10-8-84
DATE FOR REVIEW
DATE DUE 10-22-84

Adopted w/a hearing
Adopted w/o hearing
Temporary rule ✓

Approved 10-22-84 mjc Disapproved Returned to Agency

Resubmitted Due
Approved Disapproved Returned to Agency

Date filed w/Secretary of State 10/23/84 Revisor approved disapproved

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___✓___ Rule as Adopted

___✓___ Rule as Proposed see SR .

___✓___ Order Adopting 10.8.84 Date

___N/A___ Notice of Intent to Solicit Outside Opinion

___✓___ Order for rulemaking
N/A date of Hearing

___N/A___ Certificate of Board's Authorizing Resolution

___✓___ Notice of rulemaking
✓ Sufficiency

___✓___ Affidavits of Mailing Notice or rulemaking
8.29.84 At least ~~30~~ 25 days prior to ~~hearing~~/adoption

___✓___ Mailing list Certificate

___✓___ Publication in State Register
9.3.84 At least ~~30~~/20 25 days prior to ~~hearing~~/adoption

___N/A___ Hearing Examiner's Report

___✓___ Chief Hearing Examiner's Report(s)
___ Approving H.E.'s Report
___ Approving agency action

___✓___ Agency's Findings of Fact

___N/A___ LCRAR Report or agency Affidavit

___✓___ Certificate of Board's Resolution Adopting Rules

___✓___ Order Approving Incorporation by Reference

___✓___ Statement of Need and Reasonableness

___✓___ Petition for Adoption of a Rule

___✓___ Record (includes transcript or tape, exhibits, comments received by agency, requests for a hearing, and other relevant materials)

___✓___ Certificate of Compliance w/Rulemaking Procedures

___N/A___ Affidavit of Mailing Notice of Submission to Attorney General

___✓___ Notice of Submission to the Attorney General

copies are unreadable - agency requested to provide legible copies

rec'd 10/19.

SF-00006-03

STATE OF MINNESOTA

DEPARTMENT

Office Memorandum

TO: Judith Wehrwein
Attorney General/Administration

DATE: October 8, 1984

FROM: Robert G. Meyer
Department of Human Services
Health Care Programs Division

PHONE: 7-2670

SUBJECT: Minnesota Rules, Parts 9500.1450 - 9500.1474, Notice of Submission to the Attorney General and Affidavit of Mailing

In accordance with Minnesota Statutes, sections 14.30 and 14.32, I should like to notify you that under the Notice of Intent to Adopt Emergency Rules, published in the State Register on Monday, September 3, 1984, the Department had no requests to receive the Notice of Submission to the Attorney General. Therefore, the Notice of Submission to the Attorney General and the Affidavit of Mailing is not included in the rule file.

SF-00006-02

DEPARTMENT ATTORNEY GENERAL

STATE OF MINNESOTA

Office Memorandum

TO : Leonard Levine, Commissioner
Department of Human Services

DATE: October 23, 1984

ATTN: Elizabeth Cutter
Special Assistant Attorney General

FROM : Martha J. Casserly MJC
Special Assistant Attorney General

PHONE: 296-4692

SUBJECT: In the Matter of the Proposed Adoption of Emergency Rules Governing Administration of the Medical Assistance Prepaid Demonstration Project Under the Medical Assistance Program, Minnesota Rules, Parts 9500.1450 - 9500.1474 (Emergency).

Enclosed herewith are the rules you have submitted for approval. These rules have been approved by this office and filed with the Secretary of State. Please note that they have not been filed with the State Register. This must be done promptly by your agency.

Upon receipt and before transmittal to your agency, however, it is important that you recheck these rules as to:

1. Affixation of stamps of the Attorney General and Secretary of State;

2. Coverage by these stamps of all rules submitted; and

3. Inclusion of all pages to the rules in the approved set.

If you have any questions in this regard, please contact me.

MJC:slz

Encs.

cc: Ms. Kathy Burek
Mr. Duane Harves

AG copy, 1094

Department of Human Services

Adopted Emergency Rules Governing Medical Assistance Prepaid Demonstration Project

what to 13.74

Emergency Rules as Adopted

9500.1450 [Emergency] DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 9500.1450 to 9500.1473 [Emergency] have the meanings given them in this part.

Subp. 2. **Broker.** "Broker" means an organization contracted with the Department of Human Services to develop and present to consumers educational material on the MAPDP so that consumers shall understand the choices available to them.

Subp. 3. **Case management.** "Case management" means a method of health care provision in which one individual or organization or an interdisciplinary team coordinates the provision of all health care services to a consumer.

Subp. 4. **Consumer.** "Consumer" means an individual receiving medical assistance through one of the designated participant counties.

Subp. 5. **MAPDP.** "MAPDP" means the medical assistance prepaid demonstration project.

Subp. 6. **Medicaid health plan (MHP) or umbrella organization.** "Medicaid health plan (MHP)" or "umbrella organization" means the organization contracting with the Department of Human Services to provide all of the services currently available under medical assistance to consumers in exchange for a prepaid capitation payment.

Subp. 7. **Personal care attendant.** "Personal care attendant" means a provider of personal care services to a medical assistance client which are prescribed by a physician and supervised by a registered nurse. A personal care attendant may not be a relative or family member of the medical assistance client and must be enrolled with the Department of Human Services as a medical assistance provider.

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9500.1451 [Emergency] INTRODUCTION.

Subpart 1. **Scope.** Parts 9500.1450 to 9500.1475 [Emergency] govern administration of the medical assistance prepaid demonstration project (MAPDP) in Minnesota. Parts 9500.1450 to 9500.1475 [Emergency] shall be read in conjunction with title XIX of the federal Social Security Act; Code of Federal Regulations, title 42; Minnesota Statutes, chapter 256B; and rules promulgated thereunder, which govern the administration of the title XIX program and MAPDP in Minnesota.

A. For the purposes of the MAPDP, the state of Minnesota has received, under authority title XIX of the Social Security Act, section 1115(a)(1) and its implementing regulations, the following waivers of provisions:

(1) to enable the state to implement the program which would not be in effect throughout the state, as provided by the Social Security Act, section 1902(a)(1) and Code of Federal Regulations, title 42, section 431.50;

(2) to enable the state to restrict freedom of choice of provider, as provided by the Social Security Act, section 1902(a)(23) and Code of Federal Regulations, title 42, section 431.51;

(3) to enable the state to impose cost sharing on mandatory services, as provided by the Social Security Act, section 1902(a)(14) and Code of Federal Regulations, title 42, sections 447.50 to 447.58; and

(4) to allow for the release of information to brokers, as provided by the Social Security Act, section 1902(a)(7) and Code of Federal Regulations, title 42, section 431.306.

B. Expenditures to provide Medicaid to individuals which would otherwise be excluded by virtue of the Social Security Act, section 1903(i)(3) or 1903(m), will be regarded as expenditures under the state's title XIX plan for the duration of MAPDP.

Subp. 2. **Purpose.** The MAPDP shall be administered to determine if public expenditures for the medical assistance

program can be better planned, utilized, and controlled while ensuring that all participants receive necessary health care in a coordinated fashion by implementing a budgeted, prepaid ~~reimbursement~~ payment system.

Subp. 3. **Civil rights.** The MAPDP shall not be administered to deny applicants and participants their individual and civil rights, nor to disclose information regarding them except as provided under Minnesota Statutes, sections 13.01 to 13.73, and 13.75.

Subp. 4. **Jurisdiction.** Parts 9500.1450 to 9500.1475 [Emergency] are binding on participating county welfare boards, providers of services participating in MAPDP, and medical assistance recipients particpating in MAPDP as designated by the commissioner of the Department of Human Services.

Subp. 5. **References.** Parts 9500.1450 to 9500.1475 [Emergency] specifically include by reference any federal laws or regulations or state laws pertaining to the Minnesota medical assistance prepaid demonstration project, and any provision of parts 9500.1450 to 9500.1475 [Emergency] which is inconsistent with those laws is superseded by those laws.

9500.1452 [Emergency] APPLICATION PROCESS.

An applicant for MAPDP shall follow the procedures in part 9500.0770.

9500.1453 [Emergency] ELIGIBILITY FACTORS.

The applicant shall meet the eligibility standards in parts 9500.0780 to 9500.0860, as amended.

9500.1454 [Emergency] ADDITIONAL ELIGIBILITY FACTORS.

Subpart 1. **Continuing spend-down.** Only individuals meeting continuing spend-down criteria, as provided by part 9500.0810, subpart 10, shall be eligible for MAPDP. No other individual subject to the spend-down requirement of part 9500.0810, subpart 10, shall be eligible for MAPDP.

Subp. 2. **Personal care attendants.** Persons currently receiving the services of a personal care attendant shall not be eligible for MAPDP.

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Subp. 3. Current residents of institutions. Current residents of state institutions shall not be eligible for MAPDP.

Subp. 4. Refugees. Refugees who are currently recipients of the Refugee Assistance Program shall not be eligible for MAPDP.

9500.1459 [Emergency] TERMINATION OF MEDICAL ASSISTANCE THROUGH MAPDP.

MAPDP terminations must be effected according to part 9500.0860.

9500.1460 [Emergency] FREE CHOICE OF PROVIDER.

Subpart 1. Free choice. Under MAPDP, consumers shall choose among the Medicaid health plans offering a health plan in their county. At the Medicaid health plan, a case manager responsible for the coordination of an individual's health care shall assist the consumer in planning his or her health care and in choosing among the providers offered by the Medicaid health plan. The ~~county government in Dakota and Itasca counties, being the sole Medicaid health plan in its respective county,~~ counties acting as umbrella organizations for any of the medical assistance covered services shall ensure access and choice for consumers by including a ~~majority~~ sufficient number of providers in the county in ~~its~~ their Medicaid health plan.

Subp. 2. Criteria for suspension of current reimbursement system. The current reimbursement system shall not be suspended in demonstration counties unless the following criteria are met:

A. the total capacity of the MHP is equal to or greater than 110 percent of the medical assistance eligibles in that county;

B. the travel time to an MHP's primary care facility is not greater than 30 minutes; and

C. medical assistance recipients will have a choice of at least two MHPs.

These criteria may be enacted by population type.

9500.1461 [Emergency] COUNTY MAPDP PLAN.

The counties shall administer MAPDP according to part

9500.0910.

9500.1462 [Emergency] ACCURATE FILE.

The county shall be responsible for an accurate file and shall provide the information required in part 9500.0920.

9500.1463 [Emergency] RECORDS.

The state and local welfare agencies and all medical providers shall maintain medical and fiscal records as required in part 9500.0930.

9500.1464 [Emergency] THIRD-PARTY LIABILITY.

Duties of a state and local agency with respect to third-party liability shall be as required in part 9500.0940.

9500.1465 [Emergency] IDENTIFICATION OF RECIPIENTS.

A Medicaid health plan shall provide a means to identify recipients enrolled in its program which best suits its normal procedures of operation.

9500.1466 [Emergency] PROVIDER AGREEMENTS AND QUALIFICATIONS.

Providers shall execute an agreement and be eligible for MAPDP under parts 9500.0960 and 9500.0970.

9500.1467 [Emergency] UTILIZATION CONTROL.

A statewide surveillance and utilization control program shall be established under part 9500.0990.

9500.1468 [Emergency] SURVEILLANCE AND UTILIZATION REVIEW PROGRAM.

The surveillance and utilization review procedures in parts 9505.1750 to 9505.2130, and 9505.2150 apply to MAPDP.

9500.1469 [Emergency] SERVICES COVERED BY MAPDP.

Subpart 1. **In general.** The following services are covered under MAPDP.

Subp. 2. **Inpatient hospital services.** "Inpatient hospital services" are those items and services ordinarily furnished by a hospital for the care and treatment of inpatients; and which are provided under the direction of a physician or dentist in an

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institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases; and which is licensed or formally approved as a hospital by the Minnesota Department of Health; and which is qualified to participate under title XVIII of the Social Security Act or is determined currently to meet the requirements for such participation; and which has in effect a utilization review plan applicable to all patients who receive medical assistance under title XIX of the Social Security Act which meets applicable federal requirements, unless a waiver has been granted by the secretary of the Department of Health, Education, and Welfare. All inpatient hospitals certified for participation under medicare (title XVIII) are eligible to participate in MAPDP upon completion of ~~a provider~~ an agreement with a participating MHP or county umbrella organization.

The hospital shall comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures. Failure to comply with these requirements will result in denial of payment by the Department of Human Services.

Subp. 3. **Long-term care facility services.** "Long-term care facility services," as defined in part 9500.1070, subpart 3, shall be provided in accordance with parts 9500.0750 to 9500.1080.

Subp. 4. **Physician services.** Physician services are those services provided by or under the personal supervision of a licensed physician or osteopath within the scope of his or her profession as defined by state law. All physicians currently licensed to practice medicine under Minnesota law are eligible to participate in the MAPDP. Out-of-state physicians who are licensed in the state of service are also eligible for participation in Minnesota's MAPDP. The MAPDP shall include all emergency health care.

Subp. 5. **Other licensed practitioners.** The MAPDP shall include medical and remedial care or services, other than physicians' services, provided by a practitioner currently

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licensed under Minnesota law and performed within the scope of practice as defined by state law.

A. Chiropractors shall be currently licensed as chiropractors and conform to the uniform minimum standards promulgated by the secretary of health, education and welfare under title XVIII of the Social Security Act, as amended.

B. Podiatrists shall be currently licensed as podiatrists by the state of Minnesota.

C. Optometrists shall be currently licensed by the Board of Optometry. ~~Ophthalmologists shall be currently licensed by the state.~~ Also eligible for participation are opticians who are normally associated with the fabrication or dispensing of materials, and out-of-state providers in one of the above classifications licensed by the state of service.

Eyeglasses are lenses (including frames when necessary) and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist to aid or improve vision.

D. Psychologists ~~are individuals currently licensed by the Minnesota Board of Examiners of Psychologists to practice as licensed psychologists or licensed consulting psychologists in the appropriate service areas~~ shall be currently licensed as consulting psychologists or psychologists by the Board of Psychology, and shall practice only within their individual areas of competence as stated to the Board of Psychology.

E. A public health nurse is a registered nurse who is licensed as a professional nurse and certified by the State Board of Health as a public health nurse.

F. Dental services are diagnostic, preventive, or corrective procedures administered by or under the supervision of a licensed dentist. The MAPDP includes all emergency care and basic oral health needs. Dentures are artificial structures prescribed by a dentist to replace a full or partial set of teeth and made by or according to the directions of a licensed dentist.

Subp. 6. **Outpatient hospital services.** "Outpatient hospital services" are preventive, diagnostic, therapeutic,

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rehabilitative, or palliative items or services furnished by or under the direction of a licensed physician or dentist to an outpatient in an outpatient facility which is licensed as a hospital by the state and which is qualified to participate under title XVIII of the Social Security Act, or is currently determined to meet the requirements for such participation. All outpatient hospitals certified to participate under medicare, title XVIII of the Social Security Act, are eligible to participate in the MAPDP upon completion of a provider agreement.

A hospital shall comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures as set forth in Code of Federal Regulations, title 42, section 441.257 to 441.258 and Minnesota Statutes, section 252A.13. Failure to comply will result in denial of payment under the medical assistance program.

Subp. 7. **Clinic services.** "Clinic services" are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an an outpatient by or under the direction of a licensed physician or dentist in a facility which is not part of a hospital but which is organized and operated to provide medical care to outpatients. Family planning agencies or centers are considered "clinics" under this definition.

Family planning agencies are agencies or clinics which primarily offer family planning related services and have executed either a contract or provider agreement with the state agency. Family planning agencies provide services concerned with the voluntary planning of the conception and bearing of children. The services include both fertility and infertility programs.

The following are limitations to services provided by family planning agencies: the request for services must originate with the recipient and proceed with the recipient's full knowledge and consent. The agency or clinic must comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures as set forth in

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Code of Federal Regulations, title 42, sections 441.257 to 441.258 and Minnesota Statutes, section 252A.13. Failure to comply with these requirements will result in denial of payment under the medical assistance program.

Subp. 8. **Home health care services.** "Home health care services" are any of the services in items A to ~~D~~ E when they are prescribed by a licensed physician to a patient in his or her place of residence, but excluding residence in a hospital, skilled nursing facility, or intermediate care facility:

A. intermittent or part-time nursing services furnished by a home health agency;

B. intermittent or part-time nursing services of a professional registered nurse or licensed practical nurse under the direction of the patient's physician, when no home health agency services are available;

C. medical supplies, equipment, and appliances prescribed by a physician as necessary for the care of the patient and suitable for use in the home;

D. services of a home health aide under the supervision of a professional nurse assigned by a home health agency; and

E. rehabilitative and therapeutic services.

A home health agency is a public or private agency or organization, or a subdivision of an agency or organization, which is qualified to participate as a home health agency under title XVIII of the Social Security Act or is determined by the Department of Health to currently meet the requirements of applicable federal regulations.

Subp. 9. **Medical supplies.** The term "medical supplies" as used in this part includes the most cost effective nondurable medical supplies, durable medical equipment, prostheses, orthoses, and oxygen. Medical supplies must be prescribed by a physician or other licensed medical practitioner within the scope of his or her profession as defined by state law. Medical supplies must be necessary and reasonable for the treatment or diagnosis of an illness or injury or to improve a physical

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impairment or maintain the functioning of ~~a malformed~~ the affected body ~~member~~ part.

A. "Nondurable medical supplies" means those items which have a limited life expectancy (for example, atomizers, nebulizers, fountain syringes, and incontinence pads).

B. "Durable medical equipment" means equipment which can withstand repeated use, is primarily used for medical purposes, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home (for example, wheel chairs, hospital beds, and side rails).

C. "Prostheses" and "orthoses" mean 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 malfunction or to support a weak or deformed portion of the body, including hearing aids and associated batteries.

D. The MAPDP includes oxygen and any equipment necessary for administration of oxygen (or other than nasal catheters and positive pressure breathing apparatus) when prescribed by a licensed physician.

Subp. 10. **Private duty nursing services.** "Private duty nursing services" are nursing services provided by a professional registered nurse or a licensed practical nurse under the general direction of the patient's physician to the patient in his or her own home or in a hospital or skilled nursing facility, when the patient requires individual and continual care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the hospital or skilled nursing facility. Eligible providers include registered nurses and licensed practical nurses in independent practice who provide services separate and apart from any employment or contract with any agency, organization, or facility.

The MAPDP includes private duty nursing services.

Subp. 11. **Rehabilitative and therapeutic services.** "Rehabilitative and therapeutic services" are provided for the purpose of increasing or maintaining the maximum level of

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functional independence of patients. These services are defined pursuant to physician orders and when purchased by a facility, agency, or independent practitioner and include the use of supplies and equipment as necessary.

Subp. 12. **Rehabilitative and therapeutic services in long-term care facilities.** Such services must be provided in accordance with applicable federal regulations, state law, and Department of Human Services rules.

A. Physical therapy means those services ~~prescribed~~ ordered by a physician and provided to a patient by a qualified physical therapist. In addition, other qualified rehabilitative personnel, including physical therapy assistants, physical therapy aides, and physical therapy orderlies may assist the physical therapist in performing physical therapy services and in the performance of duties that do not require a qualified physical therapist's knowledge and skill. The full responsibility for the patient's instruction or treatment remains with the qualified physical therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct, on-site observation and supervision by the qualified physical therapist. A qualified physical therapist is a graduate of a school of physical therapy approved by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association, and who has a valid Minnesota certificate of registration.

B. Occupational therapy means those services prescribed by a physician and provided to a patient by a qualified occupational therapist. Other qualified rehabilitative personnel, including occupational therapy assistants, occupational therapy aides, and occupational therapy orderlies may assist the occupational therapist in performing occupational therapy services and in the performance of duties that do not require a qualified occupational therapist's knowledge and skill. The full responsibility for the patient's instruction or treatment remains with the qualified occupational

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therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct, on-site observation and supervision by the qualified occupational therapist. A qualified occupational therapist is a graduate of a school of occupational therapy approved by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association, or who is registered by the American Occupational Therapy Association.

C. Services for individuals with speech, hearing, and language disorders means those diagnostic, screening, preventive, or corrective services prescribed by a physician and provided by a qualified speech pathologist or a qualified audiologist in the practice of the profession. A qualified speech pathologist or qualified audiologist shall have a certificate of clinical competence from the American Speech and Hearing Association, or shall have completed the equivalent educational requirements and work experience necessary for obtaining a certificate, or shall have completed the academic program and be in the process of accumulating the necessary supervised work experience required to qualify for a certificate.

D. Specialized rehabilitative service requirements, inpatient and outpatient are:

(1) There must be a reasonable medical expectation that the patient's condition will improve significantly in a reasonable period. This expectation shall be based on the attending physician's assessment of the patient's potential for rehabilitation after consultation with qualified rehabilitative personnel.

(2) Physician orders must relate the necessity for specialized maintenance therapy to the patient's particular disabilities. The therapy must be necessary for maintaining the patient's current level of functioning or for preventing deterioration of the patient's condition. Specialized maintenance therapy shall be provided only by qualified rehabilitative personnel and only to those patients who cannot be adequately and appropriately treated solely within the

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facility's nursing program.

Subp. 13. **Speech pathology, audiology, and physical therapy provided by independent practitioners.** Such services are of a diagnostic, screening, preventive, or corrective nature and provided to individuals with speech, hearing, and language disorders, or physical impairments. Such services must be provided in accordance with the applicable federal regulations, state law, and Department of Human Services rules.

A. Speech pathology means those services prescribed by a licensed physician and provided to a patient by a qualified speech pathologist in independent practice. A qualified speech pathologist in independent practice shall have received a certificate of clinical competence from the American Speech and Hearing Association (ASHA) or shall have submitted to the medical assistance program an equivalency statement from ASHA indicating that ASHA certification standards have been met.

B. Audiology means those services prescribed by a licensed physician and provided to a patient by a qualified audiologist in independent practice. A qualified audiologist in independent practice shall have received the certificate of clinical competence from ASHA or shall have submitted to the medical assistance program an equivalency statement from ASHA indicating that ASHA certification standards have been met.

C. Physical therapy means those services ~~prescribed~~ ordered by a licensed physician and provided to a patient by a qualified physical therapist in independent practice. A qualified physical therapist in independent practice is a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association, has a valid Minnesota Certificate of Registration, and has been federally certified as an independent practitioner ~~by~~ through the Minnesota Department of Health.

Subp. 14. **Rehabilitation agencies.** A "rehabilitation agency" is an agency which provides an integrated multidisciplinary program designed to upgrade or maintain the

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physical function of handicapped, disabled individuals. At a minimum, a rehabilitation agency must provide physical therapy or speech pathology services, and a rehabilitation program that in addition to physical therapy or speech pathology services, includes social or vocational adjustment services. Eligible providers include all rehabilitation agencies participating in the Medicare program (title XVIII). "Rehabilitation agency services" are those medically necessary services provided by certified rehabilitation agencies in accordance with applicable federal regulations, state law, and Department of Human Services rules and defined as follows:

A. Medical services are those services provided to a patient within the scope and practice of medicine as defined by Minnesota law and performed by a currently licensed physician.

B. Psychological services are those services provided to a patient by a psychologist licensed to practice ~~in the appropriate service areas, when medically necessary~~ within his or her individual area of competence.

C. Psychosocial services are those services provided to a patient by a social worker for whom a licensed physician assumes total professional and administrative responsibility as if the services were provided by the physician. To receive reimbursement under the MAPDP all psychosocial services shall be ordered by a licensed physician.

D. Physical therapy means those services ~~prescribed~~ ordered by a licensed physician and provided to a patient by a qualified physical therapist. Other personnel may assist physical therapists in performing physical therapy services and in the performance of duties that do not require professional therapy knowledge and skill. The full responsibility for patient instruction or treatment remains with the qualified physical therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct on-site observation and supervision by the qualified physical therapist.

E. Occupational therapy are those services prescribed

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by a licensed physician and provided to a patient by a qualified occupational therapist. Other personnel may assist occupational therapists in performing occupational therapy services and in the performance of duties that do not require professional therapy knowledge and skill. The full responsibility for patient instruction or treatment remains with the qualified occupational therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct on-site observation and supervision by the qualified occupational therapist.

F. Speech pathology or audiology services for individuals with speech, hearing, and language disorders are those diagnostic, screening, preventive, or corrective services provided by a qualified speech pathologist or audiologist in the practice of his profession for which a patient is referred by a licensed physician.

G. Special services are physician-ordered and monitored evaluations, classes, clinics, or programs provided to patients generally by a rehabilitation team.

Subp. 15. **Other laboratory and X-ray services.** Other laboratory and X-ray services include professional and technical laboratory and radiological services ordered by a licensed physician, dentist, or other licensed medical practitioner within the scope of his practice as defined by state law and who is not employed by that laboratory.

Subp. 16. **Pharmacy services.** A pharmacy is a facility licensed by the State Board of Pharmacy in which prescriptions, drugs, medicines, chemicals, and poisons are compounded, dispensed, vended, or sold on a retail basis. Prescribed drugs are any simple or compounded substance or mixture of substances prescribed for the care, mitigation, or prevention of disease or for health maintenance, by a physician, dentist, or other licensed medical practitioner within the scope of his practice as defined by state law. The MAPDP covers prescribed drugs and nutritional supplements obtained from a licensed pharmacy or from a hospital in which drug dispensing is under the

supervision of a licensed pharmacist.

The following are service limitations of the medical assistance pharmacy program:

A. Pharmaceuticals must be prescribed by a licensed physician, dentist, or other authorized licensed medical practitioner. The dispensing medical practitioner must keep the signed prescription on file for five years, subject to audit at any reasonable time, and must comply with the provisions of part 9500.0930, subpart 4.

B. All prescriptions must be reduced to writing with the name of the prescribing physician shown and must be signed by the prescribing physician or the pharmacist.

C. Prescription refills: the prescriber must indicate approval for refilling the prescription. In the absence of specific refill instructions, the prescription will be interpreted to be not refillable.

Subp. 17. **Early periodic screening, diagnosis, and treatment (EPSDT).** The MAPDP includes early and periodic screening and diagnosis of individuals under the age of 21 to ascertain physical or mental defects and for health care, treatment, and other measures to correct or improve defects and chronic conditions detected. Services rendered by providers other than licensed physicians are included within MAPDP only if the Minnesota Department of Health has previously approved the screening activities.

In order to comply with federal and state EPSDT requirements, local welfare agencies shall:

A. notify in writing on an annual basis all recipients eligible for EPSDT services of the existence of the services;

B. provide or arrange for provision of screening services when they are requested;

C. arrange for corrective treatment; and

D. maintain adequate EPSDT records and report activities as required by the commissioner.

In order to comply with federal and state EPSDT

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requirements, ~~providers~~ MHPs shall follow required EPSDT billing and reporting procedures.

Subp. 18. **Other medical care.** The MAPDP includes other medical care as follows:

A. Transportation only when furnished by an enrolled medical provider licensed by the Minnesota Department of Health.

The following services rendered by medical transportation providers are not included by the MAPDP: any routine service determined by the local welfare agency not to be medically necessary and unnecessary ambulance service.

B. Emergency hospital or physician services which are necessary to prevent the death or serious impairment of the health of an individual.

C. Personal care services in a recipient's home rendered by a qualified individual, other than a member of the patient's family, when the services are prescribed by a physician and supervised by a registered nurse.

D. Whole blood, including items and services required in the collection, storage, and administration thereof, when ordered by a licensed physician and is not available to the patient from other sources.

E. Services for children with handicaps.

Subp. 19. **Mental health centers services.** "Mental health centers" are centers currently receiving grant-in-aid who are operating in accordance with parts 9520.0010 to 9520.0230. Services provided by mental health centers must be provided under the direction of a psychiatrist licensed to practice medicine in the United States or Canada or a licensed consulting psychologist, currently enrolled as an eligible provider under the medical assistance program. The MAPDP includes mental health center services provided to residents of long-term care facilities only if the attending physician assisted the development of the plan of treatment and periodically reviews that plan.

Other mental health services must be provided by participating MHPs and county umbrella organizations as

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specified in the contracts with the Department of Human Services.

Subp. 20. **Abortions.** The cost of abortion services shall be included only when the conditions under items A, B, and C are met:

A. The abortion is necessary to prevent the death of the mother. The cost of the abortion shall be covered only if the documentation in subitems (1) and (2) accompanies the provider's invoice to the state agency:

(1) the signed written statement of two physicians that it was their professional judgment that the abortion was necessary to prevent the death of the mother; and

(2) the signed written statement of the recipient that she voluntarily consented to the abortion. In the event that the recipient is physically or legally incapable of providing informed consent, consent may be obtained as is otherwise provided by law.

B. The abortion is to terminate a pregnancy which is the result of a sexual assault. The cost of the abortion shall be covered only if a report of the assault was made to a valid law enforcement agency within 48 hours of the time the assault occurred and a signed statement from the law enforcement agency accompanies the provider's invoice to the state agency. In the event the recipient was physically unable to make the report within 48 hours of the assault, the report must have been made within 48 hours after the recipient became physically able to make the report.

The statement of the law enforcement agency shall include:

(1) the name of the victim;

(2) the date of the alleged incident;

(3) the date the report was made to the law enforcement agency;

(4) the name and address of the person who signed the report to the law enforcement agency; and

(5) a statement by the law enforcement agency that the report alleges at least one of the following:

(a) the circumstances existing at the time

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of the assault caused the recipient to have a reasonable fear of imminent great bodily harm to herself or to another;

(b) the assailant was armed with a dangerous weapon or an article used or fashioned in a manner which led the recipient to reasonably believe it to be a dangerous weapon, and used or threatened to use the weapon or article to cause the complainant to submit;

(c) the assailant caused personal injury to the complainant and used force or coercion to accomplish sexual penetration; or

(d) the assailant was aided or abetted by one or more accomplices and either an accomplice used force or coercion to cause the recipient to submit, or an accomplice was armed with a dangerous weapon or an article used or fashioned in a manner to lead the complainant reasonably to believe it to be a dangerous weapon and used or threatened to use the weapon or article to cause the recipient to submit.

The provider's invoice shall also be accompanied by a statement, signed by the recipient, that her pregnancy resulted from the sexual assault reported, and a statement, signed by the recipient's physician, that in the physician's opinion the length of the pregnancy at the time of the abortion was not inconsistent with the recipient's statement.

C. The abortion is to terminate a pregnancy which is the result of incest. The cost of the abortion shall be covered only if a report of incest was made to a valid law enforcement agency prior to the time of the abortion and a signed statement from the law enforcement agency accompanies the provider's invoice to the state agency. The statement shall include:

(1) the name of the victim;

(2) the date of the alleged incident;

(3) the date the report was made to the law enforcement agency;

(4) the name and address of the person who signed the report to the law enforcement agency; and

(5) a statement by the law enforcement agency

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that the name of the relative who allegedly committed incest with the victim appears in its report.

The provider's invoice shall also be accompanied by a statement, signed by the recipient, that her pregnancy resulted from the incest reported, and a statement, signed by the recipient's physician, that in the physician's opinion the length of the pregnancy at the time of the abortion was not inconsistent with the recipient's statement.

D. For the purposes of this subpart only, the following definitions apply:

(1) "Abortion services" means medical service performed for the purpose of terminating a pregnancy. This shall not be construed to include drugs or devices which prevent implantation of the fertilized ovum, or medical procedures necessary for the termination of an ectopic pregnancy.

(2) "Assailant" means a person who allegedly committed the sexual assault reported to the law enforcement agency.

(3) "Incest" means sexual intercourse with another nearer in kin than first cousin, of the whole or half-blood.

(4) "Valid law enforcement agency" means an agency charged under applicable law with enforcement of the general penal statutes of the United States, or of any state or local jurisdiction.

9500.1470 [Emergency] CAPITATION POLICIES.

Subpart 1. **Rates.** <u>In designated demonstration areas, all medical assistance payments for service included in the project will be paid for through contract with the Medicaid health plan or county umbrella organization.</u> Capitation rates must be developed on a historical cost basis. Base rates must be determined by calculating a county average per capita cost. Presuming increased efficiency through provider-managed utilization, the actual rate offered (contractual rate) must be a specified percentage of the county average per capita cost.

The historical cost base of the rates must be fiscal year

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1982 adjusted forward to the implementation year. This adjustment must be the per capita cost increase based on Department of Human Services projections (13.9 percent for noninstitutional, 15.0 percent for institutional enrollees), taking into account all legislative changes. Adjustments must be made for 1984 legislative action only if changes affect fiscal year 1985 payments.

Rates must be adjusted on a state fiscal year basis, July 1 to June 30. The annual increase to each capitation rate must be the maximum overall service unit increase as prescribed in Minnesota Statutes, section 256.966. If an annual increase is not prescribed in law for the 1986-1987 biennium, an equivalent factor must be calculated by the commissioner.

Subp. 2. **Risk sharing arrangements.** In addition to the capitation rate, the Department of Human Services shall provide two types of risk-sharing:

A. aggregate loss-sharing; and

B. individual stop-loss for catastrophic illness cases.

Subp. 3. **Aggregate loss-sharing.** Under aggregate loss-sharing, the Department of Human Services and Medicaid health plan shall share the loss if the allowable costs exceed the aggregate payment provided through the capitation. The MAPDP is intended to demonstrate the shifting of financial risk from the Department of Human Services to the Medicaid health plans, and aggregate loss-sharing shall be phased out over the three-year implementation period~~, under~~. The following risk sharing arrangement will be used unless otherwise specified in the contract between the state and the MHP:

A. AFDC = (90 percent capitation):

(1) year 1, loss-share 50-50 up to 110 percent;

(2) year 2, loss-share 50-50 up to 100 percent; and

(3) year 3, no loss-sharing.

B. Aged, blind, disabled = (95 percent capitation):

(1) year 1, loss-share 50-50 up to 115 percent;

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(2) year 2, loss-share 50-50 up to 105 percent; and

(3) year 3, no loss-sharing.

Risk-sharing expenses must only be applied to the aggregate cost of claims for services rendered directly to enrollees. For purposes of this policy, services rendered directly shall include services provided face to face with the enrollee, consultations with the enrollee's representative, or activities resulting in telephone contact with the enrollee.

Subp. 4. **Individual stop-loss coverage.** Stop-loss coverage must be provided for 80 percent of the cost of hospital claims exceeding $15,000 for AFDC enrollees and $30,000 for the aged, blind, or disabled enrollees and over 90 days of nursing home care, ICF/MR care, or equivalent home health or personal care attendant services unless otherwise specified in the contract between the state and the MHP. For individual stop-loss, claims must be calculated according to medical assistance allowable charges.

This policy does not affect providers' opportunity to seek alternative care grants. When alternative care grants are awarded, stop-loss coverage must terminate because the cost of care shall be provided through the grant. This applies to personal care attendant services and home health care services. Individual stop-loss coverage must remain in place during the three years of the demonstration. Stop-loss coverage is that amount the Department of Human Services will pay in excess of capitation rates under the following circumstances.

Medicaid health plans may choose not to take part in the DHS stop-loss program. In order to choose another form of stop-loss coverage, the organization shall assure that:

A. there is an adequate financial reserve separate from operating funds to cover catastrophic liabilities;

B. not more than 30 percent of the organization's operating budget is medical assistance related; and

C. the Medicaid health plan waives the right of 90-day termination of contract to be replaced by 180-day

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termination notice.

The capitation rate must be adjusted to include the cost of the Department of Human Services stop-loss, however additional costs of the purchasing private reinsurance must not be covered in the capitation nor be subject to cost-sharing.

9500.1471 [Emergency] PROVIDER CRITERIA.

Subpart 1. **Standards.** Criteria for provider participation in the MAPDP have been developed to ensure a minimum set of operating standards for Medicaid health plans. Part 9500.1471 is designed to encourage provider participation in the program and to uphold the existing quality of health care in the demonstration counties. These criteria form the basis for the contractual relationship between the Department of Human Services and the Medicaid health plans.

Subp. 2. **Service array.** Medicaid health plans shall be encouraged to serve as many medical assistance eligible populations as possible. A Medicaid health plan may design services for a single population limited to aged, blind, or disabled. If a plan elects to serve AFDC, it must serve at least one other medical assistance population.

Each Medicaid health plan shall provide or ensure provision of the full array of medical assistance benefits and services as set forth in part 9500.1469 [Emergency], subpart 1, to its enrollees.

With the exception of emergency services, the Medicaid health plan shall not be liable for payment for unauthorized services rendered outside of plan.

There shall be no copayments or deductibles charged to medical assistance consumers enrolled in a MAPDP <u>for any medical assistance covered service or a service delivered as a substitute for medical assistance covered services</u>.

Medicaid health plans may either be for profit or not for profit.

Subp. 3. **Contractual arrangements.** The Medicaid health plan's written contract with the Department of Human Services must ensure the provision of services to the selected medical

assistance populations and ensure understanding of and compliance with all of the provider criteria for participation in the project.

Each Medicaid health plan shall demonstrate formal contractual arrangements with major providers to meet the service needs of its enrolled medical assistance population.

In the Medicaid health plan contract with the Department of Human Services there shall be a 90-day termination notice provision for either party. Also notification of termination of contract must be given to enrollees in plan not less than 30 days prior to cancellation. Responsibility for this notification shall be determined individually in each Medicaid health plan contract with the Department of Human Services.

Subp. 4. **Membership.** Each Medicaid health plan shall demonstrate capacity for servicing new members or enrollees.

The contract between the Department of Human Services and each Medicaid health plan must specify maximum and minimum number of enrollees based on physical and financial capabilities of Medicaid health plans.

Each Medicaid health plan shall accept all Medicaid eligible applicants wishing to enroll in its program, from the population categories or geographic areas it is targeted to serve regardless of health condition, within the enrollment capacity.

Subp. 5. **Financial requirements.** Each Medicaid health plan with Department of Human Services contracts shall be accountable for fiscal management control over the programs it sponsors or delivers.

Each Medicaid health plan shall demonstrate the capability to absorb losses either through a reserve fund or other mechanism agreed upon by the providers within each Medicaid health plan involved.

At the time of contracting with the Department of Human Services, each Medicaid health plan shall have a plan developed and approved for transferring enrollees to other delivery arrangements in the event of insolvency.

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The Department of Human Services shall be held harmless in case of insolvency of Medicaid health plans or subcontracting providers, or both, for payment of services provided while the plan was operational.

The Medicaid health plan shall accept capitation from the Department of Human Services as full payment for services.

Subp. 6. **Risk capability.** Each Medicaid health plan may share risk with other corporate entities or other subcontracting providers.

Each Medicaid health plan shall be expected to assume phased and increasing risk over the three-year period of the demonstration. Each Medicaid health plan shall be at full risk by the third year.

Subp. 7. **Marketing plan.** Each Medicaid health plan must provide, at the time of contracting with the Department of Human Services, information on marketing activities to be directed at the MAPDP target population, and must present all marketing materials for the Department of Human Services' approval. No marketing materials shall be disseminated without prior written approval from the Department of Human Services.

Subp. 8. **Data-information requirements.** Each Medicaid health plan shall provide necessary information and data to the Department of Human Services and Federal Health Care Financer Administration as set forth in the MAPDP contract to meet the project needs for:

A. administration;

B. payment;

C. quality assurance;

D. evaluation;

E. Health Care Financer Administration requirements; and

F. fraud and abuse detection.

Each Medicaid health plan shall make immediately available to the Department of Human Services ~~upon-demand~~ <u>after required notice</u> of the Department of Human Services<u>,</u> information on medical assistance related medical records and financial

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information for quality assurance and evaluation purposes and for instances of suspected fraud and abuse.

Each Medicaid health plan shall be responsible for information needs set forth at subparts 1 to 7.

Each Medicaid health plan shall agree to use the Minnesota Medicaid Information System to avoid duplication.

Each MAPDP Medicaid health plan shall be responsible for reporting to the Department of Human Services information detailed in the data-information matrix published in "Medicaid Prepayment Demonstration Project: Provider Education Booklet" (February 1984), issued by the Minnesota Department of Human Services, Bureau of Income Maintenance, Health Care Programs Division, Office of New Initiatives, 444 Lafayette Road, St. Paul, Minnesota 55101, which is incorporated by reference.

Subp. 9. **Quality assurance.** Each Medicaid health plan shall develop a quality assurance system for appropriate delivery of health and social services to the enrolled medical assistance population. Each Medicaid health plan shall be responsible for monitoring and determining its own systems and corrective actions to assure quality. The quality assurance system must be in place at the time of contracting with the Department of Human Services and must include documentation and appropriate review or conduct of:

A. All problem cases and a randomly selected review of all cases. Portions of case review shall be done by a peer and interdisciplinary procedure. The Department of Human Services may require further review of any case.

B. Utilization of service.

C. Sentinal events including mortality rates, adverse outcomes, generally preventable disease.

D. Institutionalization rates.

E. Unauthorized out-of-plan usage.

F. Medical care evaluations.

G. Medical records audits.

H. Provider and consumer grievance rates.

I. Independent enrollee satisfaction surveys.

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Subp. 10. **Enrollee grievance procedures.** Each Medicaid health plan shall have a grievance procedure or complaint system which solves enrollee complaints. The grievance procedure must be an informal system with a determination made within seven calendar days from the date the plan recieves a complaint, and a formal structure including written complaints and formal hearing arbitration, with a determination made within 30 calendar days from the date the plan receives a complaint.

The grievance procedure must be in writing. A copy must be provided and explained to each enrollee, in a language that is understandable to them.

If a consumer is dissatisfied with the response of the internal plan grievance procedure, the consumer may appeal through state procedures as provided by Minnesota Statutes, section 256.045.

Subp. 11. **Procedural changes.** Any changes in the procedure must be consistent with the provisions in this part and must be reported to the recipient at least two weeks before implementation. The process and the written material shall be approved by the Department of Human Services prior to implementation.

Subp. 12. **Medicaid health plan grievance procedures.** Each Medicaid health plan shall record all complaints, actions, and results and report to the Department of Human Services semi-annually.

If a Medicaid health plan is dissatisfied with the actions of an enrollee they may notify the Department of Human Services. It shall be explained to the enrollee in writing, with a copy given to the enrollee, that this notification shall not result in a loss of eligibility or removal from the Medicaid health plan.

The Medicaid health plan must provide for a second medical opinion when requested by the enrollee or the Department of Human Services within the plan and comply with any recommendations made by the professional advisory committee of the Department of Human Services and the appeals referee in

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response to the external formal grievance procedure.

Subp. 13. **Case management.** At the time of contracting with the Department of Human Services, Medicaid health plans must demonstrate a case management system that shall contain:

A. individual needs assessment;

B. individual care plan development and implementation; and

C. evaluation, monitoring, and revision of individual care plans.

9500.1473 [Emergency] DOCUMENTATION.

Local agencies shall document the completion of requirements in parts 9500.1450 to 9500.1475 [Emergency] on forms prescribed by the Department of Human Services.

9500.1474 [Emergency] INTERAGENCY COORDINATION.

Local agencies, including local nursing services, local head start agencies, and local school districts, shall cooperate with other agencies which provide health services to children so that duplication of services is avoided.

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STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
OCT 23 1984
Joan Anderson Growe
Secretary of State
3:15 PM

APPROVED AS TO FORM AND LEGALITY
October 22 1984
HUBERT H. HUMPHREY, III
ATTORNEY GENERAL
BY M J Cassedy
SPECIAL ASSISTANT ATTORNEY GENERAL

this is version of rules provided with initial Submission

Emergency Rules as ~~Proposed~~ Adopted (all new material)

9500.1450 [Emergency] DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 9500.1450 to 9500.1473 [Emergency] have the meanings given them in this part.

Subp. 2. **Broker.** "Broker" means an organization contracted with the Department of Human Services to develop and present to consumers educational material on the MAPDP so that consumers shall understand the choices available to them.

Subp. 3. **Case management.** "Case management" means a method of health care provision in which one individual or organization or an interdisciplinary team coordinates the provision of all health care services to a consumer.

Subp. 4. **Consumer.** "Consumer" means an individual receiving medical assistance through one of the designated participant counties.

Subp. 5. **MAPDP.** "MAPDP" means the medical assistance prepaid demonstration project.

Subp. 6. **Medicaid health plan (MHP) or umbrella organization.** "Medicaid health plan (MHP)" or "umbrella organization" means the organization contracting with the Department of Human Services to provide all of the services currently available under medical assistance to consumers in exchange for a prepaid capitation payment.

Subp. 7. **Personal care attendant.** "Personal care attendant" means a provider of personal care services to a medical assistance client which are prescribed by a physician and supervised by a registered nurse. A personal care attendant may not be a relative or family member of the medical assistance client and must be enrolled with the Department of Human Services as a medical assistance provider.

9500.1451 [Emergency] INTRODUCTION.

Subpart 1. **Scope.** Parts 9500.1450 to 9500.1475 [Emergency] govern administration of the medical assistance prepaid demonstration project (MAPDP) in Minnesota. Parts 9500.1450 to 9500.1475 [Emergency] shall be read in conjunction

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with title XIX of the federal Social Security Act; Code of Federal Regulations, title 42; Minnesota Statutes, chapter 256B; and rules promulgated thereunder, which govern the administration of the title XIX program and MAPDP in Minnesota.

A. For the purposes of the MAPDP, the state of Minnesota has received, under authority title XIX of the Social Security Act, section 1115(a)(1) and its implementing regulations, the following waivers of provisions:

(1) to enable the state to implement the program which would not be in effect throughout the state, as provided by the Social Security Act, section 1902(a)(1) and Code of Federal Regulations, title 42, section 431.50;

(2) to enable the state to restrict freedom of choice of provider, as provided by the Social Security Act, section 1902(a)(23) and Code of Federal Regulations, title 42, section 431.51;

(3) to enable the state to impose cost sharing on mandatory services, as provided by the Social Security Act, section 1902(a)(14) and Code of Federal Regulations, title 42, sections 447.50 to 447.58; and

(4) to allow for the release of information to brokers, as provided by the Social Security Act, section 1902(a)(7) and Code of Federal Regulations, title 42, section 431.306.

B. Expenditures to provide Medicaid to individuals which would otherwise be excluded by virtue of the Social Security Act, section 1903(i)(3) or 1903(m), will be regarded as expenditures under the state's title XIX plan for the duration of MAPDP.

Subp. 2. **Purpose.** The MAPDP shall be administered to determine if public expenditures for the medical assistance program can be better planned, utilized, and controlled while ensuring that all participants receive necessary health care in a coordinated fashion by implementing a budgeted, prepaid ~~reimbursement~~ system.

Subp. 3. **Civil rights.** The MAPDP shall not be

administered to deny applicants and participants their individual and civil rights, nor to disclose information regarding them except as provided under Minnesota Statutes, sections 13.01 to 13.73, and 13.75.

Subp. 4. **Jurisdiction.** Parts 9500.1450 to 9500.1475 [Emergency] are binding on participating county welfare boards, providers of services participating in MAPDP, and medical assistance recipients particpating in MAPDP as designated by the commissioner of the Department of Human Services.

Subp. 5. **References.** Parts 9500.1450 to 9500.1475 [Emergency] specifically include by reference any federal laws or regulations or state laws pertaining to the Minnesota medical assistance prepaid demonstration project, and any provision of parts 9500.1450 to 9500.1475 [Emergency] which is inconsistent with those laws is superseded by those laws.

9500.1452 [Emergency] APPLICATION PROCESS.

An applicant for MAPDP shall follow the procedures in part 9500.0770.

9500.1453 [Emergency] ELIGIBILITY FACTORS.

The applicant shall meet the eligibility standards in parts 9500.0780 to 9500.0860, as amended.

9500.1454 [Emergency] ADDITIONAL ELIGIBILITY FACTORS.

Subpart 1. **Continuing spend-down.** Only individuals meeting continuing spend-down criteria, as provided by part 9500.0810, subpart 10, shall be eligible for MAPDP. No other individual subject to the spend-down requirement of part 9500.0810, subpart 10, shall be eligible for MAPDP.

Subp. 2. **Personal care attendants.** Persons receiving the services of a personal care attendant shall not be eligible for MAPDP.

9500.1459 [Emergency] TERMINATION OF MEDICAL ASSISTANCE THROUGH MAPDP.

MAPDP terminations must be effected according to part 9500.0860.

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9500.1460 [Emergency] FREE CHOICE OF PROVIDER.

Under MAPDP, consumers shall choose among the Medicaid health plans offering a health plan in their county. At the Medicaid health plan, a case manager responsible for the coordination of an individual's health care shall assist the consumer in planning his or her health care and in choosing among the providers offered by the Medicaid health plan. The county ~~government in Dakota~~ and Itasca counties, ~~being the sole Medicaid health plan in its~~ respective county, shall ensure access and choice for consumers by including a ~~majority~~ of providers in the county in ~~its~~ Medicaid health plan.

9500.1461 [Emergency] COUNTY MAPDP PLAN.

The counties shall administer MAPDP according to part 9500.0910.

9500.1462 [Emergency] ACCURATE FILE.

The county shall be responsible for an accurate file and shall provide the information required in part 9500.0920.

9500.1463 [Emergency] RECORDS.

The state and local welfare agencies and all medical providers shall maintain medical and fiscal records as required in part 9500.0930.

9500.1464 [Emergency] THIRD-PARTY LIABILITY.

Duties of a state and local agency with respect to third-party liability shall be as required in part 9500.0940.

9500.1465 [Emergency] IDENTIFICATION OF RECIPIENTS.

A Medicaid health plan shall provide a means to identify recipients enrolled in its program which best suits its normal procedures of operation.

9500.1466 [Emergency] PROVIDER AGREEMENTS AND QUALIFICATIONS.

Providers shall execute an agreement and be eligible for MAPDP under parts 9500.0960 and 9500.0970.

9500.1467 [Emergency] UTILIZATION CONTROL.

page 4

after line 11, insert:

Subp. 2 Criteria for suspension of current reimbursement system. The current reimbursement system shall not be suspended in demonstration counties unless the following criteria are met. 1) The total capacity of the MHP's is equal to or greater than 110% of the MA eligibles in that county. 2) The travel time to an MHP's primary care facility is not greater than 30 minutes. 3) MA recipients will have a choice of at least 2 MHP's.

These criteria may be enacted by population type.

A statewide surveillance and utilization control program shall be established under part 9500.0990.

9500.1468 [Emergency] SURVEILLANCE AND UTILIZATION REVIEW PROGRAM.

The surveillance and utilization review procedures in parts 9505.1750 to 9505.2130, and 9505.2150 apply to MAPDP.

9500.1469 [Emergency] SERVICES COVERED BY MAPDP.

Subpart 1. **In general.** The following services are covered under MAPDP.

Subp. 2. **Inpatient hospital services.** "Inpatient hospital services" are those items and services ordinarily furnished by a hospital for the care and treatment of inpatients; and which are provided under the direction of a physician or dentist in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases; and which is licensed or formally approved as a hospital by the Minnesota Department of Health; and which is qualified to participate under title XVIII of the Social Security Act or is determined currently to meet the requirements for such participation; and which has in effect a utilization review plan applicable to all patients who receive medical assistance under title XIX of the Social Security Act which meets applicable federal requirements, unless a waiver has been granted by the secretary of the Department of Health, Education, and Welfare. All inpatient hospitals certified for participation under medicare (title XVIII) are eligible to participate in MAPDP upon completion of ~~a provider~~ agreement.

The hospital shall comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures. Failure to comply with these requirements will result in denial of payment by the Department of Human Services.

Subp. 3. **Long-term care facility services.** "Long-term care facility services," as defined in part 9500.1070, subpart 3, shall be provided in accordance with parts 9500.0750 to

9500.1080.

Subp. 4. **Physician services.** Physician services are those services provided by or under the personal supervision of a licensed physician or osteopath within the scope of his or her profession as defined by state law. All physicians currently licensed to practice medicine under Minnesota law are eligible to participate in the MAPDP. Out-of-state physicians who are licensed in the state of service are also eligible for participation in Minnesota's MAPDP. The MAPDP shall include all emergency health care.

Subp. 5. **Other licensed practitioners.** The MAPDP shall include medical and remedial care or services, other than physicians' services, provided by a practitioner currently licensed under Minnesota law and performed within the scope of practice as defined by state law.

A. Chiropractors shall be currently licensed as chiropractors and conform to the uniform minimum standards promulgated by the secretary of health, education and welfare under title XVIII of the Social Security Act, as amended.

B. Podiatrists shall be currently licensed as podiatrists by the state of Minnesota.

C. Optometrists shall be currently licensed by the Board of Optometry. ~~Ophthalmologists shall be currently~~ licensed by the state. Also eligible for participation are opticians who are normally associated with the fabrication or dispensing of materials, and out-of-state providers in one of the above classifications licensed by the state of service.

D. Psychologists ~~are individuals currently licensed~~ by the Minnesota Board of Examiners of Psychologists to practice as ~~licensed psychologists~~ or licensed consulting psychologists in the appropriate service areas.

E. A public health nurse is a registered nurse who is licensed as a professional nurse and certified by the State Board of Health as a public health nurse.

F. Dental services are diagnostic, preventive, or corrective procedures administered by or under the supervision

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Page 6, after line 27, insert:

Eyeglasses are lenses (including frames when necessary) and other aids to vision prescribed by a physician skilled in diseases of the the eye or an optometrist to aid or improve vision.

of a licensed dentist. The MAPDP includes all emergency care and basic oral health needs. Dentures are artificial structures prescribed by a dentist to replace a full or partial set of teeth and made by or according to the directions of a licensed dentist.

Subp. 6. **Outpatient hospital services.** "Outpatient hospital services" are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a licensed physician or dentist to an outpatient in an outpatient facility which is licensed as a hospital by the state and which is qualified to participate under title XVIII of the Social Security Act, or is currently determined to meet the requirements for such participation. All outpatient hospitals certified to participate under medicare, title XVIII of the Social Security Act, are eligible to participate in the MAPDP upon completion of a provider agreement.

A hospital shall comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures as set forth in Code of Federal Regulations, title 42, section 441.257 to 441.258 and Minnesota Statutes, section 252A.13. Failure to comply will result in denial of payment under the medical assistance program.

Subp. 7. **Clinic services.** "Clinic services" are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an an outpatient by or under the direction of a licensed physician or dentist in a facility which is not part of a hospital but which is organized and operated to provide medical care to outpatients. Family planning agencies or centers are considered "clinics" under this definition.

Family planning agencies are agencies or clinics which primarily offer family planning related services and have executed either a contract or provider agreement with the state agency. Family planning agencies provide services concerned with the voluntary planning of the conception and bearing of children. The services include both fertility and infertility

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programs.

The following are limitations to services provided by family planning agencies: the request for services must originate with the recipient and proceed with the recipient's full knowledge and consent. The agency or clinic must comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures as set forth in Code of Federal Regulations, title 42, sections 441.257 to 441.258 and Minnesota Statutes, section 252A.13. Failure to comply with these requirements will result in denial of payment under the medical assistance program.

Subp. 8. **Home health care services.** "Home health care services" are any of the services in items A to D when they are prescribed by a licensed physician to a patient in his place of residence, but excluding residence in a hospital, skilled nursing facility, or intermediate care facility:

A. intermittent or part-time nursing services furnished by a home health agency;

B. intermittent or part-time nursing services of a professional registered nurse or licensed practical nurse under the direction of the patient's physician, when no home health agency services are available;

C. medical supplies, equipment, and appliances prescribed by a physician as necessary for the care of the patient and suitable for use in the home;

D. services of a home health aide under the supervision of a professional nurse assigned by a home health agency.

A home health agency is a public or private agency or organization, or a subdivision of an agency or organization, which is qualified to participate as a home health agency under title XVIII of the Social Security Act or is determined by the Department of Health to currently meet the requirements of applicable federal regulations.

Subp. 9. **Medical supplies.** The term "medical supplies" as used in this part includes the most cost effective nondurable

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medical supplies, durable medical equipment, prostheses, orthoses, and oxygen. Medical supplies must be prescribed by a physician or other licensed medical practitioner within the scope of his profession as defined by state law. Medical supplies must be necessary and reasonable for the treatment or diagnosis of an illness or injury or to improve the functioning of ~~a malformed~~ body ~~member.~~ part

A. "Nondurable medical supplies" means those items which have a limited life expectancy (for example, atomizers, nebulizers, fountain syringes, and incontinence pads).

B. "Durable medical equipment" means equipment which can withstand repeated use, is primarily used for medical purposes, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home (for example, wheel chairs, hospital beds, and side rails).

C. "Prostheses" and "orthoses" mean 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 malfunction or to support a weak or deformed portion of the body.

D. The MAPDP includes oxygen and any equipment necessary for administration of oxygen (or other than nasal catheters and positive pressure breathing apparatus) when prescribed by a licensed physician.

Subp. 10. **Private duty nursing services.** "Private duty nursing services" are nursing services provided by a professional registered nurse or a licensed practical nurse under the general direction of the patient's physician to the patient in his or her own home or in a hospital or skilled nursing facility, when the patient requires individual and continual care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the hospital or skilled nursing facility. Eligible providers include registered nurses and licensed practical nurses in independent practice who provide services separate and apart from any employment or contract with any agency, organization, or facility.

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The MAPDP includes private duty nursing services.

Subp. 11. **Rehabilitative and therapeutic services.** "Rehabilitative and therapeutic services" are provided for the purpose of increasing or maintaining the maximum level of functional independence of patients. These services are defined pursuant to physician orders and when purchased by a facility, agency, or independent practitioner and include the use of supplies and equipment as necessary.

Subp. 12. **Rehabilitative and therapeutic services in long-term care facilities.** Such services must be provided in accordance with applicable federal regulations, state law, and Department of Human Services rules.

A. Physical therapy means those services ~~prescribed~~ ordered by a physician and provided to a patient by a qualified physical therapist. In addition, other qualified rehabilitative personnel, including physical therapy assistants, physical therapy aides, and physical therapy orderlies may assist the physical therapist in performing physical therapy services and in the performance of duties that do not require a qualified physical therapist's knowledge and skill. The full responsibility for the patient's instruction or treatment remains with the qualified physical therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct, on-site observation and supervision by the qualified physical therapist. A qualified physical therapist is a graduate of a school of physical therapy approved by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association, and who has a valid Minnesota certificate of registration.

B. Occupational therapy means those services prescribed by a physician and provided to a patient by a qualified occupational therapist. Other qualified rehabilitative personnel, including occupational therapy assistants, occupational therapy aides, and occupational therapy orderlies may assist the occupational therapist in performing

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occupational therapy services and in the performance of duties that do not require a qualified occupational therapist's knowledge and skill. The full responsibility for the patient's instruction or treatment remains with the qualified occupational therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct, on-site observation and supervision by the qualified occupational therapist. A qualified occupational therapist is a graduate of a school of occupational therapy approved by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association, or who is registered by the American Occupational Therapy Association.

C. Services for individuals with speech, hearing, and language disorders means those diagnostic, screening, preventive, or corrective services prescribed by a physician and provided by a qualified speech pathologist or a qualified audiologist in the practice of the profession. A qualified speech pathologist or qualified audiologist shall have a certificate of clinical competence from the American Speech and Hearing Association, or shall have completed the equivalent educational requirements and work experience necessary for obtaining a certificate, or shall have completed the academic program and be in the process of accumulating the necessary supervised work experience required to qualify for a certificate.

D. Specialized rehabilitative service requirements, inpatient and outpatient are:

(1) There must be a reasonable medical expectation that the patient's condition will improve significantly in a reasonable period. This expectation shall be based on the attending physician's assessment of the patient's potential for rehabilitation after consultation with qualified rehabilitative personnel.

(2) Physician orders must relate the necessity for specialized maintenance therapy to the patient's particular disabilities. The therapy must be necessary for maintaining the patient's current level of functioning or for preventing

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deterioration of the patient's condition. Specialized maintenance therapy shall be provided only by qualified rehabilitative personnel and only to those patients who cannot be adequately and appropriately treated solely within the facility's nursing program.

Subp. 13. **Speech pathology, audiology, and physical therapy provided by independent practitioners.** Such services are of a diagnostic, screening, preventive, or corrective nature and provided to individuals with speech, hearing, and language disorders, or physical impairments. Such services must be provided in accordance with the applicable federal regulations, state law, and Department of Human Services rules.

A. Speech pathology means those services prescribed by a licensed physician and provided to a patient by a qualified speech pathologist in independent practice. A qualified speech pathologist in independent practice shall have received a certificate of clinical competence from the American Speech and Hearing Association (ASHA) or shall have submitted to the medical assistance program an equivalency statement from ASHA indicating that ASHA certification standards have been met.

B. Audiology means those services prescribed by a licensed physician and provided to a patient by a qualified audiologist in independent practice. A qualified audiologist in independent practice shall have received the certificate of clinical competence from ASHA or shall have submitted to the medical assistance program an equivalency statement from ASHA indicating that ASHA certification standards have been met.

C. Physical therapy means those services ~~prescribed~~ by a licensed physician and provided to a patient by a qualified physical therapist in independent practice. A qualified physical therapist in independent practice is a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association, has a valid Minnesota Certificate of Registration, and has been certified as an independent practitioner ~~by~~ the Minnesota Department of

Health.

Subp. 14. **Rehabilitation agencies.** A "rehabilitation agency" is an agency which provides an integrated multidisciplinary program designed to upgrade the physical function of handicapped, disabled individuals. At a minimum, a rehabilitation agency must provide physical therapy or speech pathology services, and a rehabilitation program that in addition to physical therapy or speech pathology services, includes social or vocational adjustment services. Eligible providers include all rehabilitation agencies participating in the Medicare program (title XVIII). "Rehabilitation agency services" are those services provided by certified rehabilitation agencies in accordance with applicable federal regulations, state law, and Department of Human Services rules and defined as follows:

A. Medical services are those services provided to a patient within the scope and practice of medicine as defined by Minnesota law and performed by a currently licensed physician.

B. Psychological services are those services provided to a patient by a psychologist licensed to practice in the appropriate service areas, when medically necessary.

C. Psychosocial services are those services provided to a patient by a social worker for whom a licensed physician assumes total professional and administrative responsibility as if the services were provided by the physician. To receive reimbursement under the MAPDP all psychosocial services shall be ordered by a licensed physician.

D. Physical therapy means those services ~~prescribed~~ by a licensed physician and provided to a patient by a qualified physical therapist. Other personnel may assist physical therapists in performing physical therapy services and in the performance of duties that do not require professional therapy knowledge and skill. The full responsibility for patient instruction or treatment remains with the qualified physical therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct

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on-site observation and supervision by the qualified physical therapist.

E. Occupational therapy are those services prescribed by a licensed physician and provided to a patient by a qualified occupational therapist. Other personnel may assist occupational therapists in performing occupational therapy services and in the performance of duties that do not require professional therapy knowledge and skill. The full responsibility for patient instruction or treatment remains with the qualified occupational therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct on-site observation and supervision by the qualified occupational therapist.

F. Speech pathology or audiology services for individuals with speech, hearing, and language disorders are those diagnostic, screening, preventive, or corrective services provided by a qualified speech pathologist or audiologist in the practice of his profession for which a patient is referred by a licensed physician.

G. Special services are physician-ordered and monitored evaluations, classes, clinics, or programs provided to patients generally by a rehabilitation team.

Subp. 15. **Other laboratory and X-ray services.** Other laboratory and X-ray services include professional and technical laboratory and radiological services ordered by a licensed physician, dentist, or other licensed medical practitioner within the scope of his practice as defined by state law and who is not employed by that laboratory.

Subp. 16. **Pharmacy services.** A pharmacy is a facility licensed by the State Board of Pharmacy in which prescriptions, drugs, medicines, chemicals, and poisons are compounded, dispensed, vended, or sold on a retail basis. Prescribed drugs are any simple or compounded substance or mixture of substances prescribed for the care, mitigation, or prevention of disease or for health maintenance, by a physician, dentist, or other licensed medical practitioner within the scope of his practice

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as defined by state law. The MAPDP covers prescribed drugs obtained from a licensed pharmacy or from a hospital in which drug dispensing is under the supervision of a licensed pharmacist.

The following are service limitations of the medical assistance pharmacy program:

A. Pharmaceuticals must be prescribed by a licensed physician, dentist, or other authorized licensed medical practitioner. The dispensing medical practitioner must keep the signed prescription on file for five years, subject to audit at any reasonable time, and must comply with the provisions of part 9500.0930, subpart 4.

B. All prescriptions must be reduced to writing with the name of the prescribing physician shown and must be signed by the prescribing physician or the pharmacist.

C. Prescription refills: the prescriber must indicate approval for refilling the prescription. In the absence of specific refill instructions, the prescription will be interpreted to be not refillable.

Subp. 17. **Early periodic screening, diagnosis, and treatment (EPSDT).** The MAPDP includes early and periodic screening and diagnosis of individuals under the age of 21 to ascertain physical or mental defects and for health care, treatment, and other measures to correct or improve defects and chronic conditions detected. Services rendered by providers other than licensed physicians are included within MAPDP only if the Minnesota Department of Health has previously approved the screening activities.

In order to comply with federal and state EPSDT requirements, local welfare agencies shall:

A. notify in writing on an annual basis all recipients eligible for EPSDT services of the existence of the services;

B. provide or arrange for provision of screening services when they are requested;

C. arrange for corrective treatment; and

D. maintain adequate EPSDT records and report activities as required by the commissioner.

In order to comply with federal and state EPSDT requirements, ~~providers~~ shall follow required EPSDT billing and reporting procedures.

Subp. 18. **Other medical care.** The MAPDP includes other medical care as follows:

A. Transportation only when furnished by an enrolled medical provider licensed by the Minnesota Department of Health. The following services rendered by medical transportation providers are not included by the MAPDP: any routine service determined by the local welfare agency not to be medically necessary and unnecessary ambulance service.

B. Emergency hospital services which are necessary to prevent the death or serious impairment of the health of an individual.

C. Personal care services in a recipient's home rendered by a qualified individual, other than a member of the patient's family, when the services are prescribed by a physician and supervised by a registered nurse.

D. Whole blood, including items and services required in the collection, storage, and administration thereof, when ordered by a licensed physician and is not available to the patient from other sources.

Subp. 19. **Mental health ~~centers~~.** A. "Mental health centers" are centers currently receiving grant-in-aid who are operating in accordance with parts 9520.0010 to 9520.0230. Services provided by mental health centers must be provided under the direction of a psychiatrist licensed to practice medicine in the United States or Canada or a licensed consulting psychologist, currently enrolled as an eligible provider under the medical assistance program. The MAPDP includes mental health center services provided to residents of long-term care facilities only if the attending physician assisted the development of the plan of treatment and periodically reviews that plan.

Subp. 20. **Abortions.** The cost of abortion services shall

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page 16, after line 35, insert:

B. Other mental health services must be provided by participating MHPs and county umbrella organizations as specified in the contracts with the Department of Human Services.

be included only when the conditions under items A, B, and C are met:

A. The abortion is necessary to prevent the death of the mother. The cost of the abortion shall be covered only if the documentation in subitems (1) and (2) accompanies the provider's invoice to the state agency:

(1) the signed written statement of two physicians that it was their professional judgment that the abortion was necessary to prevent the death of the mother; and

(2) the signed written statement of the recipient that she voluntarily consented to the abortion. In the event that the recipient is physically or legally incapable of providing informed consent, consent may be obtained as is otherwise provided by law.

B. The abortion is to terminate a pregnancy which is the result of a sexual assault. The cost of the abortion shall be covered only if a report of the assault was made to a valid law enforcement agency within 48 hours of the time the assault occurred and a signed statement from the law enforcement agency accompanies the provider's invoice to the state agency. In the event the recipient was physically unable to make the report within 48 hours of the assault, the report must have been made within 48 hours after the recipient became physically able to make the report.

The statement of the law enforcement agency shall include:

(1) the name of the victim;

(2) the date of the alleged incident;

(3) the date the report was made to the law enforcement agency;

(4) the name and address of the person who signed the report to the law enforcement agency; and

(5) a statement by the law enforcement agency that the report alleges at least one of the following:

(a) the circumstances existing at the time of the assault caused the recipient to have a reasonable fear of imminent great bodily harm to herself or to another;

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(b) the assailant was armed with a dangerous weapon or an article used or fashioned in a manner which led the recipient to reasonably believe it to be a dangerous weapon, and used or threatened to use the weapon or article to cause the complainant to submit;

(c) the assailant caused personal injury to the complainant and used force or coercion to accomplish sexual penetration; or

(d) the assailant was aided or abetted by one or more accomplices and either an accomplice used force or coercion to cause the recipient to submit, or an accomplice was armed with a dangerous weapon or an article used or fashioned in a manner to lead the complainant reasonably to believe it to be a dangerous weapon and used or threatened to use the weapon or article to cause the recipient to submit.

The provider's invoice shall also be accompanied by a statement, signed by the recipient, that her pregnancy resulted from the sexual assault reported, and a statement, signed by the recipient's physician, that in the physician's opinion the length of the pregnancy at the time of the abortion was not inconsistent with the recipient's statement.

C. The abortion is to terminate a pregnancy which is the result of incest. The cost of the abortion shall be covered only if a report of incest was made to a valid law enforcement agency prior to the time of the abortion and a signed statement from the law enforcement agency accompanies the provider's invoice to the state agency. The statement shall include:

(1) the name of the victim;

(2) the date of the alleged incident;

(3) the date the report was made to the law enforcement agency;

(4) the name and address of the person who signed the report to the law enforcement agency; and

(5) a statement by the law enforcement agency that the name of the relative who allegedly committed incest with the victim appears in its report.

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The provider's invoice shall also be accompanied by a statement, signed by the recipient, that her pregnancy resulted from the incest reported, and a statement, signed by the recipient's physician, that in the physician's opinion the length of the pregnancy at the time of the abortion was not inconsistent with the recipient's statement.

D. For the purposes of this subpart only, the following definitions apply:

(1) "Abortion services" means medical service performed for the purpose of terminating a pregnancy. This shall not be construed to include drugs or devices which prevent implantation of the fertilized ovum, or medical procedures necessary for the termination of an ectopic pregnancy.

(2) "Assailant" means a person who allegedly committed the sexual assault reported to the law enforcement agency.

(3) "Incest" means sexual intercourse with another nearer in kin than first cousin, of the whole or half-blood.

(4) "Valid law enforcement agency" means an agency charged under applicable law with enforcement of the general penal statutes of the United States, or of any state or local jurisdiction.

9500.1470 [Emergency] CAPITATION POLICIES.

Subpart 1. **Rates** * Capitation rates must be developed on a historical cost basis. Base rates must be determined by calculating a county average per capita cost. Presuming increased efficiency through provider-managed utilization, the actual rate offered (contractual rate) must be a specified percentage of the county average per capita cost.

The historical cost base of the rates must be fiscal year 1982 adjusted forward to the implementation year. This adjustment must be the per capita cost increase based on Department of Human Services projections (13.9 percent for noninstitutional, 15.0 percent for institutional enrollees), taking into account all legislative changes. Adjustments must

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Page 19, line 25, after the first Rates., insert:

In designated demonstration areas, all MA payments for services included in the project will be paid for through contract with the Medicaid Health Plan or County umbrella organization.

be made for 1984 legislative action only if changes affect fiscal year 1985 payments.

Rates must be adjusted on a state fiscal year basis, July 1 to June 30. The annual increase to each capitation rate must be the maximum overall service unit increase as prescribed in Minnesota Statutes, section 256.966. If an annual increase is not prescribed in law for the 1986-1987 biennium, an equivalent factor must be calculated by the commissioner.

Subp. 2. **Risk sharing arrangements.** In addition to the capitation rate, the Department of Human Services shall provide two types of risk-sharing:

A. aggregate loss-sharing; and

B. individual stop-loss for catastrophic illness cases.

Subp. 3. **Aggregate loss-sharing.** Under aggregate loss-sharing, the Department of Human Services and Medicaid health plan shall share the loss if the allowable costs exceed the aggregate payment provided through the capitation. The MAPDP is intended to demonstrate the shifting of financial risk from the Department of Human Services to the Medicaid health plans, and aggregate loss-sharing shall be phased out over the three-year implementation period. ~~under~~ The following risk sharing arrangements will be used between the state and the MHP.

A. AFDC = (90 percent capitation):

(1) year 1, loss-share 50-50 up to 110 percent;

(2) year 2, loss-share 50-50 up to 100 percent; and

(3) year 3, no loss-sharing.

B. Aged, blind, disabled = (95 percent capitation):

(1) year 1, loss-share 50-50 up to 115 percent;

(2) year 2, loss-share 50-50 up to 105 percent; and

(3) year 3, no loss-sharing.

Risk-sharing expenses must only be applied to the aggregate cost of claims for services rendered directly to enrollees. For purposes of this policy, services rendered directly shall

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include services provided face to face with the enrollee, consultations with the enrollee's representative, or activities resulting in telephone contact with the enrollee.

Subp. 4. **Individual stop-loss coverage.** Stop-loss coverage must be provided for 80 percent of the cost of hospital claims exceeding $15,000 for AFDC enrollees and $30,000 for the aged, blind, or disabled enrollees and over 90 days of nursing home care or equivalent home health or personal care attendant services. For individual stop-loss, claims must be calculated according to medical assistance allowable charges.

This policy does not affect providers' opportunity to seek alternative care grants. When alternative care grants are awarded, stop-loss coverage must terminate because the cost of care shall be provided through the grant. This applies to personal care attendant services and home health care services. Individual stop-loss coverage must remain in place during the three years of the demonstration. Stop-loss coverage is that amount the Department of Human Services will pay in excess of capitation rates under the following circumstances.

Medicaid health plans may choose not to take part in the DHS stop-loss program. In order to choose another form of stop-loss coverage, the organization shall assure that:

A. there is an adequate financial reserve separate from operating funds to cover catastrophic liabilities;

B. not more than 30 percent of the organization's operating budget is medical assistance related; and

C. the Medicaid health plan waives the right of 90-day termination of contract to be replaced by 180-day termination notice.

The capitation rate must be adjusted to include the cost of the Department of Human Services stop-loss, however additional costs of the purchasing private reinsurance must not be covered in the capitation nor be subject to cost-sharing.

9500.1471 [Emergency] PROVIDER CRITERIA.

Subpart 1. **Standards.** Criteria for provider participation in the MAPDP have been developed to ensure a minimum set of

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operating standards for Medicaid health plans. Part 9500.1471 is designed to encourage provider participation in the program and to uphold the existing quality of health care in the demonstration counties. These criteria form the basis for the contractual relationship between the Department of Human Services and the Medicaid health plans.

Subp. 2. **Service array.** Medicaid health plans shall be encouraged to serve as many medical assistance eligible populations as possible. A Medicaid health plan may design services for a single population limited to aged, blind, or disabled. If a plan elects to serve AFDC, it must serve at least one other medical assistance population.

Each Medicaid health plan shall provide or ensure provision of the full array of medical assistance benefits and services as set forth in part 9500.1469 [Emergency], subpart 1, to its enrollees.

With the exception of emergency services, the Medicaid health plan shall not be liable for payment for unauthorized services rendered outside of plan.

There shall be no copayments or deductibles charged to medical assistance consumers enrolled in a MAPDP.

Medicaid health plans may either be for profit or not for profit.

Subp. 3. **Contractual arrangements.** The Medicaid health plan's written contract with the Department of Human Services must ensure the provision of services to the selected medical assistance populations and ensure understanding of and compliance with all of the provider criteria for participation in the project.

Each Medicaid health plan shall demonstrate formal contractual arrangements with major providers to meet the service needs of its enrolled medical assistance population.

In the Medicaid health plan contract with the Department of Human Services there shall be a 90-day termination notice provision for either party. Also notification of termination of contract must be given to enrollees in plan not less than 30

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days prior to cancellation. Responsibility for this notification shall be determined individually in each Medicaid health plan contract with the Department of Human Services.

Subp. 4. **Membership.** Each Medicaid health plan shall demonstrate capacity for servicing new members or enrollees.

The contract between the Department of Human Services and each Medicaid health plan must specify maximum and minimum number of enrollees based on physical and financial capabilities of Medicaid health plans.

Each Medicaid health plan shall accept all Medicaid eligible applicants wishing to enroll in its program, from the population categories or geographic areas it is targeted to serve regardless of health condition, within the enrollment capacity.

Subp. 5. **Financial requirements.** Each Medicaid health plan with Department of Human Services contracts shall be accountable for fiscal management control over the programs it sponsors or delivers.

Each Medicaid health plan shall demonstrate the capability to absorb losses either through a reserve fund or other mechanism agreed upon by the providers within each Medicaid health plan involved.

At the time of contracting with the Department of Human Services, each Medicaid health plan shall have a plan developed and approved for transferring enrollees to other delivery arrangements in the event of insolvency.

The Department of Human Services shall be held harmless in case of insolvency of Medicaid health plans or subcontracting providers, or both, for payment of services provided while the plan was operational.

The Medicaid health plan shall accept capitation from the Department of Human Services as full payment for services.

Subp. 6. **Risk capability.** Each Medicaid health plan may share risk with other corporate entities or other subcontracting providers.

Each Medicaid health plan shall be expected to assume phased and increasing risk over the three-year period of the

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demonstration. Each Medicaid health plan shall be at full risk by the third year.

Subp. 7. **Marketing plan.** Each Medicaid health plan must provide, at the time of contracting with the Department of Human Services, information on marketing activities to be directed at the MAPDP target population, and must present all marketing materials for the Department of Human Services' approval. No marketing materials shall be disseminated without prior written approval from the Department of Human Services

Subp. 8. **Data-information requirements.** Each Medicaid health plan shall provide necessary information and data to the Department of Human Services and Federal Health Care Financer Administration as set forth in the MAPDP contract to meet the project needs for:

A. administration;

B. payment;

C. quality assurance;

D. evaluation;

E. Health Care Financer Administration requirements; and

F. fraud and abuse detection.

Each Medicaid health plan shall make immediately available to the Department of Human Services ~~upon demand~~ of the Department of Human Services, information on medical assistance related medical records and financial information for quality assurance and evaluation purposes and for instances of suspected fraud and abuse.

Each Medicaid health plan shall be responsible for information needs set forth at subparts 1 to 7.

Each Medicaid health plan shall agree to use the Minnesota Medicaid Information System to avoid duplication.

Each MAPDP Medicaid health plan shall be responsible for reporting to the Department of Human Services information detailed in the data-information matrix published in "Medicaid Prepayment Demonstration Project: Provider Education Booklet" (February 1984), issued by the Minnesota Department of Human

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Services, Bureau of Income Maintenance, Health Care Programs Division, Office of New Initiatives, 444 Lafayette Road, St. Paul, Minnesota 55101, which is incorporated by reference.

Subp. 9. **Quality assurance.** Each Medicaid health plan shall develop a quality assurance system for appropriate delivery of health and social services to the enrolled medical assistance population. Each Medicaid health plan shall be responsible for monitoring and determining its own systems and corrective actions to assure quality. The quality assurance system must be in place at the time of contracting with the Department of Human Services and must include documentation and appropriate review or conduct of:

A. All problem cases and a randomly selected review of all cases. Portions of case review shall be done by a peer and interdisciplinary procedure. The Department of Human Services may require further review of any case.

B. Utilization of service.

C. Sentinal events including mortality rates, adverse outcomes, generally preventable disease.

D. Institutionalization rates.

E. Unauthorized out-of-plan usage.

F. Medical care evaluations.

G. Medical records audits.

H. Provider and consumer grievance rates.

I. Independent enrollee satisfaction surveys.

Subp. 10. **Enrollee grievance procedures.** Each Medicaid health plan shall have a grievance procedure or complaint system which solves enrollee complaints. The grievance procedure must be an informal system with a determination made within seven calendar days from the date the plan recieves a complaint, and a formal structure including written complaints and formal hearing arbitration, with a determination made within 30 calendar days from the date the plan receives a complaint.

The grievance procedure must be in writing. A copy must be provided and explained to each enrollee, in a language that is understandable to them.

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If a consumer is dissatisfied with the response of the internal plan grievance procedure, the consumer may appeal through state procedures as provided by Minnesota Statutes, section 256.045.

Subp. 11. **Procedural changes.** Any changes in the procedure must be consistent with the provisions in this part and must be reported to the recipient at least two weeks before implementation. The process and the written material shall be approved by the Department of Human Services prior to implementation.

Subp. 12. **Medicaid health plan grievance procedures.** Each Medicaid health plan shall record all complaints, actions, and results and report to the Department of Human Services semi-annually.

If a Medicaid health plan is dissatisfied with the actions of an enrollee they may notify the Department of Human Services. It shall be explained to the enrollee in writing, with a copy given to the enrollee, that this notification shall not result in a loss of eligibility or removal from the Medicaid health plan.

The Medicaid health plan must provide for a second medical opinion when requested by the enrollee or the Department of Human Services within the plan and comply with any recommendations made by the professional advisory committee of the Department of Human Services and the appeals referee in response to the external formal grievance procedure.

Subp. 13. **Case management.** At the time of contracting with the Department of Human Services, Medicaid health plans must demonstrate a case management system that shall contain:

A. individual needs assessment;

B. individual care plan development and implementation; and

C. evaluation, monitoring, and revision of individual care plans.

9500.1473 [Emergency] DOCUMENTATION.

Local agencies shall document the completion of

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requirements in parts 9500.1450 to 9500.1475 [Emergency] on forms prescribed by the Department of Human Services.

9500.1474 [Emergency] INTERAGENCY COORDINATION.

Local agencies, including local nursing services, local head start agencies, and local school districts, shall cooperate with other agencies which provide health services to children so that duplication of services is avoided.

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OFFICE OF THE REVISOR OF STATUTES

Proposed Rule

RD589E

Agency: Department of Human Services

Division: Income Maintenance

Agency Contact: Richard Deeg
Bob Meyer

Minnesota Rules: Parts 9500.1450 to 9500.1475 [Emergency]

Title: Proposed Emergency Rules Governing Medical Assistance Prepaid Demonstration Project

Type of Rules: Emergency

Incorporations by Reference: None

Steven C. Cross
Revisor of Statutes

Susan M. Lentsch
Assistant Revisor
Phone: 296-0956
Date: August 20, 1984

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF EMERGENCY RULES GOVERNING ADMINISTRATION OF THE MEDICAL ASSISTANCE PREPAID DEMONSTRATION PROJECT UNDER THE MEDICAL ASSISTANCE PROGRAM, MINNESOTA RULES, PARTS 9500.1450 - 9500.1474 (EMERGENCY).

ORDER ADOPTING EMERGENCY RULES

The above-entitled matter was published in the State Register on September 3, 1984, as a proposed emergency rule pursuant to Minnesota Statutes, sections 14.29 - 14.36.

After affording interested and affected persons an opportunity to submit written data and views within 25 days of the publication date, reviewing and considering the data and views, and determining that the above-captioned rules are needed and reasonable,

NOW, THEREFORE, IT IS ORDERED that these rules identified as emergency rules Governing Administration of the Medical Assistance Prepaid Demonstration Project under the Medical Assistance Program.

are adopted this 8 day of October, 1984, pursuant to authority vested in me by Minnesota Statutes, sections 256.991 and 256B.69 to 256B.70.

STATE OF MINNESOTA

COMMISSIONER OF HUMAN SERVICES

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of Emergency Rules of the State Administration of the Medical Assistance Prepaid Demonstration Project Under the Medical Assistance Program, Governing Minnesota Rules, parts 9500.1450 to 9500.1474 [Emergency]

ORDER FOR PUBLICATION OF EMERGENCY RULES

IT IS ORDERED this 17 day of August 1984 that the proposed emergency rules in the above-entitled matter be published in the State Register.

STATE OF MINNESOTA

LEONARD W. LEVINE
Commissioner of Human Services

EW-33

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

Proposed Emergency Rules Governing
Administration of the Medical Assistance
Prepaid Demonstration Project Under the
Medical Assistance Program,
Minnesota Rules, parts 9500.1450 to
9500.1474 [Emergency]

NOTICE OF INTENT TO
ADOPT EMERGENCY RULES

The State Department of Human Services proposes to adopt the above-entitled emergency rules to implement Minnesota Statutes, sections 256.991 and 256B.69 to 256B.70.

Persons interested in these rules have until 4:30 on September 28, 1984 to submit written comments. The proposed emergency rules may be modified if the modifications are supported by the data and views submitted to the agency and do not result in a substantial change in the proposed language. Written comments should be sent to:

Robert G. Meyer
Department of Human Services
Bureau of Income Maintenance
Health Care Programs Division
Office of New Initiatives
444 Lafayette Road
St. Paul, MN 55101
Telephone: 612/297-2670

Upon adoption of these emergency rules, this notice, all written comments received, and the adopted emergency rules will be delivered to the Attorney General and to the Revisor of Statutes for review as to form and legality.

Notice of the date of submission of the proposed emergency rule to the attorney general will be mailed to any person requesting to receive this notice. The Attorney General shall approve or disapprove the proposed emergency rule and any modifications on the tenth working day following the date of receipt of the proposed emergency rule from the agency.

The adopted emergency rules will not become effective without the Attorney General's approval and the Revisor of Statutes' certification of the rules' form. Emergency rules take effect five working days after approval by the Attorney General.

As required by Minnesota Statutes, sections 14.29 to 14.36 and 256.991, these emergency rules shall be in effect for up to 360 days following their adoption and may be continued in effect for an additional 900 days if the Commissioner gives notice of continuation by publishing notice in the State Register and mailing the same notice to all persons registered with the Commissioner to receive notice of rulemaking proceedings. The emergency rules shall not be effective beyond December 31, 1986, without following the procedures in Minnesota Statutes, sections 14.13 to 14.20.

Minnesota Rules, Parts 9500.1450 to 9500.1474 [Emergency] establishes a demonstration project to determine whether or not public expenditures for medical assistance can be better controlled while ensuring that all participants receive necessary health care in a coordinated fashion by implementing a budgeted, prepaid reimbursement system. Part 9500.1451 [Emergency] lists the waivers of provisions under Title XIX of the Federal Social Security Act for implementation of the project, and establishes the rights and responsibilities of the Department of Human Services, county welfare boards, providers of services, and recipients of medical assistance participation in the demonstration project. Parts 9500.1452 to 9500.1460 [Emergency] establishes eligibility factors and free choice of providers for recipients. Parts 9500.1461 to 9500.1469 [Emergency] establishes planning, record keeping, utilization control and covered services provisions. Parts 9500.1470 to 9500.1474 [Emergency] establishes capitation policies, provider criteria, documentation and interagency coordination provisions.

These emergency rules will not result in any additional state or county spending beyond the amount of funds appropriated by the legislature.

A free copy of the proposed emergency rule may be obtained by contacting Robert G. Meyer, Department of Human Services, Bureau of Income Maintenance, Health Care Programs Division, Office of New Initiatives, 444 Lafayette Road, St. Paul, MN 55101.



LEONARD W. LEVINE
Commissioner of Human Services

EW-31

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF PROPOSED EMERGENCY RULES GOVERNING ADMINISTRATION OF THE MEDICAL ASSISTANCE PREPAID DEMONSTRATION PROJECT UNDER THE MEDICAL ASSISTANCE PROGRAM, MINNESOTA RULES, PARTS 9500.1450 to 9500.1474 (Emergency)

AFFIDAVIT OF MAILING

Wendy Johnson , being first duly sworn, deposes and says:

That on the 29 day of August , 1984, at the City of St. Paul, County of Ramsey, State of Minnesota, she served the attached Notice of Intent to Adopt Emergency Rules by depositing in the State of Minnesota Central Mail System for first class mailing, a copy thereof, properly enveloped, with postage prepaid, on all persons and associations who have requested that their names be placed on file with the Department of Human Services for the purpose of receiving notice of the proposed adoption of rules by this Department.

Wendy Johnson

Subscribed and sworn to before me

this 30 day of August, 1984.

Margaret Holt

MARGARET HOLT
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
My Comm. Expires Sept. 22, 1988

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF PROPOSED EMERGENCY RULES GOVERNING ADMINISTRATION OF THE MEDICAL ASSISTANCE PREPAID DEMONSTRATION PROJECT UNDER THE MEDICAL ASSISTANCE PROGRAM, MINNESOTA RULES, PARTS 9500.1450 to 9500.1474 (Emergency)

AFFIDAVIT OF ADDITIONAL MAILING

Wendy Johnson , being first duly sworn, deposes and says:

That on the 29 day of August , 1984, at the City of St. Paul, County of Ramsey, State of Minnesota, in addition to serving the attached Notice of Intent to Adopt Emergency Rules to all persons and associations who have requested that their names be placed on file with for the purpose of receiving notice of the proposed adoption of rules by this Department, she also served the attached Notice by depositing in the State of Minnesota Central Mail System for first class mailing, a copy thereof, properly enveloped, with postage prepaid to the following agencies:

MN Medical Assoc.s
Senior Federations
Handicap Coalitions
HMO's
ARC
Health Care Assoc.s and Advocates

State of MN Departments, Agencies, Senate, House
Additional persons who requested notification

Wendy Johnson

Subscribed and sworn to before me

this 30 day of August, 1984.

Margaret Holt

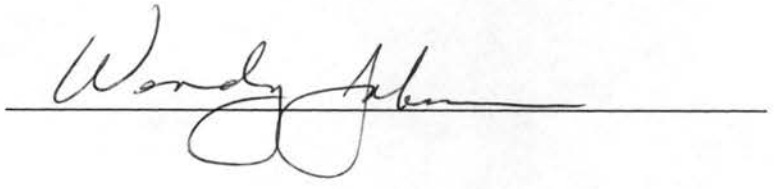
MARGARET HOLT
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
My Comm. Expires Sept. 22, 1985

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF PROPOSED EMERGENCY RULES GOVERNING ADMINISTRATION OF THE MEDICAL ASSISTANCE PREPAID DEMONSTRATION PROJECT UNDER THE MEDICAL ASSISTANCE PROGRAM, MINNESOTA RULES, PARTS 9500.1450 to 9500.1474 (Emergency)

CERTIFICATE

I hereby certify that the list of persons, associations, and other interested groups who have requested, pursuant to Minn. Stat. S.14.14, subd. 1, that their names be placed on file with and maintained by the Department of Human Services for the purpose of receiving notice of the proposed adoption of rules by this Department is accurate and complete as of 6:00, P.M., this 29 day of August, 1984.



A, subitems (2) and (3) unless the excess is expressly authorized under contract and provided only with local agency funds.

D. If more than one qualified provider provides the special services in subpart 9 to an applicant or recipient, the reimbursement to each qualified provider for his costs, fees, and disbursements shall be the amount derived by multiplying the total amount of interim funds retained by the local agency as in subpart 10, item A, subitems (2) and (3) by the qualified provider's reimbursement percentage. The qualified provider's reimbursement percentage is determined by dividing each qualified provider's total number of hours of special services by the total number of hours of special services provided by the local agency and all other qualified providers under contract who have served the applicant or recipient.

E. The services in subpart 9, when provided during the six-month period prior to an application for general assistance, shall be reimbursed if the local agency determines that the services contributed substantially to the applicant's or recipient's obtaining SSI benefits. The reimbursement shall be made only if interim funds remain after reimbursement for services rendered subsequent to the application for general assistance.

F. If the applicant or recipient and the local agency agree to terminate a contract with a qualified provider, the contract for special services for that applicant or recipient shall be terminated.

G. The local agency and a qualified provider may agree through contract to jointly provide the special services of subpart 9.

Department of Human Services

Proposed Emergency Rules Governing Medical Assistance Prepaid Demonstration Project

Notice of Intent to Adopt Emergency Rules

The State Department of Human Services proposes to adopt the above-entitled emergency rules to implement Minnesota Statutes, sections 256.991 and 256B.69 to 256B.70.

Persons interested in these rules have until 4:30 on September 28, 1984 to submit written comments. The proposed emergency rules may be modified if the modifications are supported by the data and views submitted to the agency and do not result in a substantial change in the proposed language. Written comments should be sent to:

Robert G. Meyer
Department of Human Services
Bureau of Income Maintenance
Health Care Programs Division
Office of New Initiatives
444 Lafayette Road
St. Paul, MN 55101
Telephone: 612/297-2670

Upon adoption of these emergency rules, this notice, all written comments received, and the adopted emergency rules will be delivered to the Attorney General and to the Revisor of Statutes for review as to form and legality.

Notice of the date of submission of the proposed emergency rule to the attorney general will be mailed to any person requesting to receive this notice. The Attorney General shall approve or disapprove the proposed emergency rule and any modifications on the tenth working day following the date of receipt of the proposed emergency rule from the agency.

The adopted emergency rules will not become effective without the Attorney General's approval and the Revisor of Statutes' certification of the rules' form. Emergency rules take effect five working days after approval by the Attorney General.

As required by Minnesota Statutes, sections 14.29 to 14.36 and 256.991, these emergency rules shall be in effect for up to 360 days following their adoption and may be continued in effect for an additional 900 days if the Commissioner gives notice of continuation by publishing notice in the *State Register* and mailing the same notice to all persons registered with the Commissioner to receive notice of rulemaking proceedings. The emergency rules shall not be effective beyond December 31, 1986 without following the procedures in Minnesota Statutes, sections 14.13 to 14.20.

Minnesota Rules, Parts 9500.1450 to 9500.1474 [Emergency] establishes a demonstration project to determine whether or not public expenditures for medical assistance can be better controlled while ensuring that all participants receive necessary health care in a coordinated fashion by implementing a budgeted, prepaid reimbursement system. Part 9500.1451 [Emergency] lists the waivers of provisions under Title XIX of the Federal Social Security Act for implementation of the

project, and establishes the rights and responsibilities of the Department of Human Services, county welfare boards, providers of services, and recipients of medical assistance participation in the demonstration project. Parts 9500.1452 to 9500.1460 [Emergency] establishes eligibility factors and free choice of providers for recipients. Parts 9500.1461 to 9500.1469 [Emergency] establishes planning, record keeping, utilization control and covered services provisions. Parts 9500.1470 to 9500.1474 [Emergency] establishes capitation policies, provider criteria, documentation and interagency coordination provisions.

These emergency rules will not result in any additional state or county spending beyond the amount of funds appropriated by the Legislature.

A free copy of the proposed emergency rule may be obtained by contacting Robert G. Meyer, Department of Human Services, Bureau of Income Maintenance, Health Care Programs Division, Office of New Initiatives, 444 Lafayette Road, St. Paul, MN 55101.

Leonard W. Levine
Commissioner of Human Services

Emergency Rules as Proposed (all new material)

9500.1450 [Emergency] DEFINITIONS.

Subpart 1. Scope. The terms used in parts 9500.1450 to 9500.1473 [Emergency] have the meanings given them in this part.

Subp. 2. Broker. "Broker" means an organization contracted with the Department of Human Services to develop and present to consumers educational material on the MAPDP so that consumers shall understand the choices available to them.

Subp. 3. Case management. "Case management" means a method of health care provision in which one individual or organization coordinates the provision of all health care services to a consumer.

Subp. 4. Consumer. "Consumer" means an individual receiving medical assistance through one of the designated participant counties.

Subp. 5. MAPDP. "MAPDP" means the medical assistance prepaid demonstration project.

Subp. 6. Medicaid health plan (MHP) or umbrella organization. "Medicaid health plan (MHP)" or "umbrella organization" means the organization contracting with the Department of Human Services to provide all of the services currently available under medical assistance to consumers in exchange for a prepaid capitation payment.

Subp. 7. Personal care attendant. "Personal care attendant" means a provider of personal care services to a medical assistance client which are prescribed by a physician and supervised by a registered nurse. A personal care attendant may not be a relative or family member of the medical assistance client and must be enrolled with the Department of Human Services as a medical assistance provider.

9500.1451 [Emergency] INTRODUCTION.

Subpart 1. Scope. Parts 9500.1450 to 9500.1475 [Emergency] govern administration of the medical assistance prepaid demonstration project (MAPDP) in Minnesota. Parts 9500.1450 to 9500.1475 [Emergency] shall be read in conjunction with title XIX of the federal Social Security Act; Code of Federal Regulations, title 42; Minnesota Statutes, chapter 256B; and rules promulgated thereunder, which govern the administration of the title XIX program and MAPDP in Minnesota.

A. For the purposes of the MAPDP, the state of Minnesota has received, under authority title XIX of the Social Security Act, section 1115(a)(1) and its implementing regulations, the following waivers of provisions:

(1) to enable the state to implement the program which would not be in effect throughout the state, as provided by the Social Security Act, section 1902(a)(1) and Code of Federal Regulations, title 42, section 431.50;

(2) to enable the state to restrict freedom of choice of provider, as provided by the Social Security Act, section 1902(a)(23) and Code of Federal Regulations, title 42, section 431.51;

(3) to enable the state to impose cost sharing on mandatory services, as provided by the Social Security Act, section 1902(a)(14) and Code of Federal Regulations, title 42, sections 447.50 to 447.58; and

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(4) to allow for the release of information to brokers, as provided by the Social Security Act, section 1902(a)(7) and Code of Federal Regulations, title 42, section 431.306.

B. Expenditures to provide Medicaid to individuals which would otherwise be excluded by virtue of the Social Security Act, section 1903(i)(3) or 1903(m), will be regarded as expenditures under the state's title XIX plan for the duration of MAPDP.

Subp. 2. Purpose. The MAPDP shall be administered to determine if public expenditures for the medical assistance program can be better planned, utilized, and controlled while ensuring that all participants receive necessary health care in a coordinated fashion by implementing a budgeted, prepaid reimbursement system.

Subp. 3. Civil rights. The MAPDP shall not be administered to deny applicants and participants their individual and civil rights, nor to disclose information regarding them except as provided under Minnesota Statutes, sections 13.01 to 13.73, and 13.75.

Subp. 4. Jurisdiction. Parts 9500.1450 to 9500.1475 [Emergency] are binding on participating county welfare boards, providers of services participating in MAPDP, and medical assistance recipients participating in MAPDP as designated by the commissioner of the Department of Human Services.

Subp. 5. References. Parts 9500.1450 to 9500.1475 [Emergency] specifically include by reference any federal laws or regulations or state laws pertaining to the Minnesota medical assistance prepaid demonstration project, and any provision of parts 9500.1450 to 9500.1475 [Emergency] which is inconsistent with those laws is superseded by those laws.

9500.1452 [Emergency] APPLICATION PROCESS.

An applicant for MAPDP shall follow the procedures in part 9500.0770.

9500.1453 [Emergency— ELIGIBILITY FACTORS.

The applicant shall meet the eligibility standards in parts 9500.0780 to 9500.0860, as amended.

9500.1454 [Emergency] ADDITIONAL ELIGIBILITY FACTORS.

Subpart 1. Continuing spend-down. Only individuals meeting continuing spend-down criteria, as provided by part 9500.0810, subpart 10, shall be eligible for MAPDP. No other individual subject to the spend-down requirement of part 9500.0810, subpart 10, shall be eligible for MAPDP.

Subp. 2. Personal care attendants. Persons receiving the services of a personal care attendant shall not be eligible for MAPDP.

9500.1450 [Emergency] TERMINATION OF MEDICAL ASSISTANCE THROUGH MAPDP.

MAPDP terminations must be effected according to part 9500.0860.

9500.1460 [Emergency] FREE CHOICE OF PROVIDER.

Under MAPDP, consumers shall choose among the Medicaid health plans offering a health plan in their county. At the Medicaid health plan, a case manager responsible for the coordination of an individual's health care shall assist the consumer in planning his or her health care and in choosing among the providers offered by the Medicaid health plan. The county government in Dakota and Itasca counties, being the sole Medicaid health plan in its respective county, shall ensure access and choice for consumers by including a majority of providers in the county in its Medicaid health plan.

9500.1461 [Emergency] COUNTY MAPDP PLAN.

The counties shall administer MAPDP according to part 9500.0910.

9500.1462 [Emergency] ACCURATE FILE.

The county shall be responsible for an accurate file and shall provide the information required in part 9500.0920.

9500.1463 [Emergency] RECORDS.

The state and local welfare agencies and all medical providers shall maintain medical and fiscal records as required in part 9500.0930.

9500.1464 [Emergency] THIRD-PARTY LIABILITY.

Duties of a state and local agency with respect to third-part liability shall be as required in part 9500.0940.

9500.1465 [Emergency] IDENTIFICATION OF RECIPIENTS.

A Medicaid health plan shall provide a means to identify recipients enrolled in its program which best suits its normal procedures of operation.

9500.1466 [Emergency] PROVIDER AGREEMENTS AND QUALIFICATIONS.

Providers shall execute an agreement and be eligible for MAPDP under part/9500.0960 and 9500.0970.

9500.1467 [Emergency] UTILIZATION CONTROL.

A statewide surveillance and utilization control program shall be established under part 9500.0990.

9500.1468 [Emergency] SURVEILLANCE AND UTILIZATION REVIEW PROGRAM.

The surveillance and utilization review procedures in parts 9505.1750 to 9505.2130, and 9505.2150 apply to MAPDP.

9500.1469 [Emergency] SERVICES COVERED BY MAPDP.

Subpart 1. In general. The following services are covered under MAPDP.

Subp. 2. Inpatient hospital services. "Inpatient hospital services" are those items and services ordinarily furnished by a hospital for the care and treatment of inpatients; and which are provided under the direction of a physician or dentist in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases; and which is licensed or formally approved as a hospital by the Minnesota Department of Health; and which is qualified to participate under title XVIII of the Social Security Act or is determined currently to meet the requirements for such participation; and which has in effect a utilization review plan applicable to all patients who receive medical assistance under title XIX of the Social Security Act which meets applicable federal requirements, unless a waiver has been granted by the secretary of the Department of Health, Education, and Welfare. All inpatient hospitals certified for participation under medicare (title XVIII) are eligible to participate in MAPDP upon completion of a provider agreement.

The hospital shall comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures. Failure to comply with these requirements will result in denial of payment by the Department of Human Services.

Subp. 3. Long-term care facility services. "Long-term care facility services," as defined in part 9500.1070, subpart 3, shall be provided in accordance with parts 9500.0750 to 9500.1080.

Subp. 4. Physician services. Physician services are those services provided by or under the personal supervision of a licensed physician or osteopath within the scope of his or her profession as defined by state law. All physicians currently licensed to practice medicine under Minnesota law are eligible to participate in the MAPDP. Out-of-state physicians who are licensed in the state of service are also eligible for participation in Minnesota's MAPDP. The MAPDP shall include all emergency health care.

Subp. 5. Other licensed practitioners. The MAPDP shall include medical and remedial care or services, other than physicians' services, provided by a practitioner currently licensed under Minnesota law and performed within the scope of practice as defined by state law.

A. Chiropractors shall be currently licensed as chiropractors and conform to the uniform minimum standards promulgated by the secretary of health, education and welfare under title XVIII of the Social Security Act, as amended.

B. Podiatrists shall be currently licensed as podiatrists by the state of Minnesota.

C. Optometrists shall be currently licensed by the Board of Optometry. Ophthalmologists shall be currently licensed by the state. Also eligible for participation are opticians who are normally associated with the fabrication or dispensing of materials, and out-of-state providers in one of the above classifications licensed by the state of service.

D. Psychologists are individuals currently licensed by the Minnesota Board of Examiners of Psychologists to practice as licensed psychologists or licensed consulting psychologists in the appropriate service areas.

E. A public health nurse is a registered nurse who is licensed as a professional nurse and certified by the State Board of Health as a public health nurse.

F. Dental services are diagnostic, preventive, or corrective procedures administered by or under the supervision of a licensed dentist. The MAPDP includes all emergency care and basic oral health needs. Dentures are artificial structures prescribed by a dentist to replace a full or partial set of teeth and made by or according to the directions of a licensed dentist.

Subp. 6. Outpatient hospital services. "Outpatient hospital services" are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a licensed physician or dentist to an

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outpatient in an outpatient facility which is licensed as a hospital by the state and which is qualfied to participate under title XVIII of the Social Security Act, or is currently determined to meet the requirements for such participation. All outpatient hospitals certified to participate under medicare, title XVIII of the Social Security Act, are eligible to participate in the MAPDP upon completion of a provider agreement.

A hospital shall comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures as set forth in Code of Federal Regulations, title 42, section 441.257 to 441.258 and Minnesota Statutes, section 252A.13. Failure to comply will result in denial of payment under the medical assistance program.

Subp. 7. Clinic services. "Clinic services" are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a licensed physician or dentist in a facility which is not part of a hospital but which is organized and operated to provide medical care to outpatients. Family planning agencies or centers are considered "clinics" under this definition.

Family planning agencies are agencies or clinics which primarily offer family planning related services and have executed either a contract or provider agreement with the state agency. Family planning agencies provide services concerned with the voluntary planning of the conception and bearing of children. The services include both fertility and infertility programs.

The following are limitations to services provided by family planning agencies: the request for services must originate with the recipient and proceed with the recipient's full knowledge and consent. The agency or clinic must comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures as set forth in Code of Federal Regulations, title 42, sections 441.257 to 441.258 and Minnesota Statutes, section 252A.13. Failure to comply with these requirements will result in denial of payment under the medical assistance program.

Subp. 8. Home health care services. "Home health care services" are any of the services in items A to D when they are prescribed by a licensed physician to a patient in his place of residence, but excluding residence in a hospital, skilled nursing facility, or intermediate care facility:

A. intermittent or part-time nursing services furnished by a home health agency;

B. intermittent or part-time nursing services of a professional registered nurse or licensed practical nurse under the direction of the patient's physician, when no home health agency services are available;

C. medical supplies, equipment, and appliances prescribed by a physician as necessary for the care of the patient and suitable for use in the home;

D. services of a home health aide under the supervision of a professional nurse assigned by a home health agency.

A home health agency is a public or private agency or organization, or a subdivision of an agency or organization, which is qualified to participate as a home health agency under title XVIII of the Social Security Act or is determined by the Department of Health to currently meet the requirements of applicable federal regulations.

Subp. 9. Medical supplies. The term "medical supplies" as used in this part includes the most cost effective nondurable medical supplies, durable medical equipment, prostheses, orthoses, and oxygen. Medical supplies must be prescribed by a physician or other licensed medical practitioner within the scope of his profession as defined by state law. Medical supplies must be necessary and reasonable for the treatment or diagnosis of an illness or injury or to improve the functioning of a malformed body member.

A. "Nondurable medical supplies" means those items which have a limited life expectancy (for example, atomizers, nebulizers, fountain syringes, and incontinence pads).

B. "Durable medical equipment" means equipment which can withstand repeated use, is primarily used for medical purposes, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home (for example, wheel chairs, hospital beds, and side rails).

C. "Prostheses" and "orthoses" .mean 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 malfunction or to support a weak or deformed portion of the body.

D. The MAPDP includes oxygen and any equipment necessary for administration of oxygen (or other than nasal catheters and positive pressure breathing apparatus) when prescribed by a licensed physician.

Subp. 10. Private duty nursing services. "Private duty nursing services" are nursing services provided by a professional registered nurse or a licensed practical nurse under the general direction of the patient's physician to the patient in his or her own home or in a hospital or skilled nursing facility, when the patient requires individual and continual care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the hospital or skilled nursing facility. Eligible providers include registered nurses and licensed practical nurses in independent practice who provide services separate and apart from any employment or contract with any agency, organization, or facility.

The MAPDP includes private duty nursing services.

Subp. 11. Rehabilitative and therapeutic services. "Rehabilitative and therapeutic services" are provided for the purpose of increasing or maintaining the maximum level of functional independence of patients. These services are defined pursuant to physician orders and when purchased by a facility, agency, or independent practitioner and include the use of supplies and equipment as necessary.

Subp. 12. Rehabilitative and therapeutic services in long-term care facilities. Such services must be provided in accordance with applicable federal regulations, state law, and Department of Human Services rules.

A. Physical therapy means those services prescribed by a physician and provided to a patient by a qualified physical therapist. In addition, other qualified rehabilitative personnel, including physical therapy assistants, physical therapy aides, and physical therapy orderlies may assist the physical therapist in performing physical therapy services and in the performance of duties that do not require a qualified physical therapist's knowledge and skill. The full responsibility for the patient's instruction or treatment remains with the qualified physical therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct, on-site observation and supervision by the qualified physical therapist. A qualified physical therapist is a graduate of a school of physical therapy approved by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association, and who has a valid Minnesota certificate of registration.

B. Occupational therapy means those services prescribed by a physician and provided to a patient by a qualified occupational therapist. Other qualified rehabilitative personnel, including occupational therapy assistants, occupational therapy aides, and occupational therapy orderlies may assist the occupational therapist in performing occupational therapy services and in the performance of duties that do not require a qualified occupational therapist's knowledge and skill. The full responsibility for the patient's instruction or treatment remains with the qualified occupational therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct, on-site observation and supervision by the qualified occupational therapist. A qualified occupational therapist is a graduate of a school of occupational therapy approved by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association, or who is registered by the American Occupational Therapy Association.

C. Services for individuals with speech, hearing, and language disorders means those diagnostic, screening, preventive, or corrective services prescribed by a physician and provided by a qualified speech pathologist or a qualified audiologist in the practice of the profession. A qualified speech pathologist or qualified audiologist shall have a certificate of clinical competence from the American Speech and Hearing Association, or shall have completed the equivalent educational requirements and work experience necessary for obtaining a certificate, or shall have completed the academic program and be in the process of accumulating the necessary supervised work experience required to qualify for a certificate.

D. Specialized rehabilitative service requirements, inpatient and outpatient are:

(1) There must be a reasonable medical expectation that the patient's condition will improve significantly in a reasonable period. This expectation shall be based on the attending physician's assessment of the patient's potential for rehabilitation after consultation with qualified rehabilitative personnel.

(2) Physician orders must relate the necessity for specialized maintenance therapy to the patient's particular disabilities. The therapy must be necessary for maintaining the patient's current level of functioning or for preventing deterioration of the patient's condition. Specialized maintenance therapy shall be provided only by qualified rehabilitative personnel and only to those patients who cannot be adequately and appropriately treated solely within the facility's nursing program.

Subp. 13. Speech pathology, audiology, and physical therapy provided by independent practitioners. Such services are of a diagnostic, screening, preventive, or corrective nature and provided to individuals with speech, hearing, and language disorders, or physical impairments. Such services must be provided in accordance with the applicable federal regulations, state law, and Department of Human Services rules.

A. Speech pathology means those services prescribed by a licensed physician and provided to a patient by a qualified speech pathologist in independent practice. A qualified speech pathologist in independent practice shall have received a certificate of clinical competence from the American Speech and Hearing Association (ASHA) or shall have

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submitted to the medical assistance program an equivalency statement from ASHA indicating that ASHA certification standards have been met.

B. Audiology means those services prescribed by a licensed physician and provided to a patient by a qualified audiologist in independent practice. A qualified audiologist in independent practice shall have received the certificate of clinical competence from ASHA or shall have submitted to the medical assistance program an equivalency statement from ASHA indicating that ASHA certification standards have been met.

C. Physical therapy means those services prescribed by a licensed physician and provided to a patient by a qualified physical therapist in independent practice. A qualified physical therapist in independent practice is a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association, has a valid Minnesota Certificate of Registration, and has been certified as an independent practitioner by the Minnesota Department of Health.

Subp. 14. Rehabilitation agencies. A "rehabilitation agency" is an agency which provides an integrated multidisciplinary program designed to upgrade the physical function of handicapped, disabled individuals. At a minimum, a rehabilitation agency must provide physical therapy or speech pathology services, and a rehabilitation program that in addition to physical therapy or speech pathology services, includes social or vocational adjustment services. Eligible providers include all rehabilitation agencies participating in the Medicare program (title XVIII). "Rehabilitation agency services" are those services provided by certified rehabilitation agencies in accordance with applicable federal regulations, state law, and Department of Human Services rules and defined as follows:

A. Medical services are those services provided to a patient within the scope and practice of medicine as defined by Minnesota law and performed by a currently licensed physician.

B. Psychological services are those services provided to a patient by a psychologist licensed to practice in the appropriate service areas, when medically necessary.

C. Psychosocial services are those services provided to a patient by a social worker for whom a licensed physician assumes total professional and administrative responsibility as if the services were provided by the physician. To receive reimbursement under the MAPDP all psychosocial services shall be ordered by a licensed physician.

D. Physical therapy means those services prescribed by a licensed physician and provided to a patient by a qualified physical therapist. Other personnel may assist physical therapists in performing physical therapy services and in the performance of duties that do not require professional therapy knowledge and skill. The full responsibility for patient instruction or treatment remains with the qualified physical therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct on-site observation and supervision by the qualified physical therapist.

E. Occupational therapy are those services prescribed by a licensed physician and provided to a patient by a qualified occupational therapist. Other personnel may assist occupational therapists in performing occupational therapy services and in the performance of duties that do not require professional therapy knowledge and skill. The full responsibility for patient instruction or treatment remains with the qualified occupational therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct on-site observation and supervision by the qualified occupational therapist.

F. Speech pathology or audiology services for individuals with speech, hearing, and language disorders are those diagnostic, screening, preventive, or corrective services provided by a qualified speech pathologist or audiologist in the practice of his profession for which a patient is referred by a licensed physician.

G. Special services are physician-ordered and monitored evaluations, classes, clinics, or programs provided to patients generally by a rehabilitation team.

Subp. 15. Other laboratory and X-ray services. Other laboratory and X-ray services include professional and technical laboratory and radiological services ordered by a licensed physician, dentist, or other licensed medical practitioner within the scope of his practice as defined by state law and who is not employed by that laboratory.

Subp. 16. Pharmacy services. A pharmacy is a facility licensed by the State Board of Pharmacy in which prescriptions, drugs, medicines, chemicals, and poisons are compounded, dispensed, vended, or sold on a retail basis. Prescribed drugs are any simple or compounded substance or mixture of substances prescribed for the care, mitigation, or prevention of disease or for health maintenance, by a physician, dentist, or other licensed medical practitioner within the scope of his practice as defined by state law. The MAPDP covers prescribed drugs obtained from a licensed pharmacy or from a hospital in which drug dispensing is under the supervision of a licensed pharmacist.

The following are service limitations of the medical assistance pharmacy program:

A. Pharmaceuticals must be prescribed by a licensed physician, dentist, or other authorized licensed medical practitioner. The dispensing medical practitioner must keep the signed prescription on file for five years, subject to audit at any reasonable time, and must comply with the provisions of part 9500.0930, subpart 4.

B. All prescriptions must be reduced to writing with the name of the prescribing physician shown and must be signed by the prescribing physician or the pharmacist.

C. Prescription refills: the prescriber must indicate approval for refilling the prescription. In the absence of specific refill instructions, the prescription will be interpreted to be not refillable.

Subp. 17. Early periodic screening, diagnosis, and treatment (EPSDT). The MAPDP includes early and periodic screening and diagnosis of individuals under the age of 21 to ascertain physical or mental defects and for health care, treatment, and other measures to correct or improve defects and chronic conditions detected. Services rendered by providers other than licensed physicians are included within MAPDP only if the Minnesota Department of Health has previously approved the screening activities.

In order to comply with federal and state EPSDT requirements, local welfare agencies shall:

A. notify in writing on an annual basis all recipients eligible for EPSDT services of the existence of the services;

B. provide or arrange for provision of screening services when they are requested;

C. arrange for corrective treatment; and

D. maintain adequate EPSDT records and report activities as required by the commissioner.

In order to comply with federal and state EPSDT requirements, providers shall follow required EPSDT billing and reporting procedures.

Subp. 18. Other medical care. The MAPDP includes other medical care as follows:

A. Transportation only when furnished by an enrolled medical provider licensed by the Minnesota Department of Health.

The following services rendered by medical transportation providers are not included by the MAPDP: any routine service determined by the local welfare agency not to be medically necessary and unnecessary ambulance service.

B. Emergency hospital services which are necessary to prevent the death or serious impairment of the health of an individual.

C. Personal care services in a recipient's home rendered by a qualified individual, other than a member of the patient's family, when the services are prescribed by a physician and supervised by a registered nurse.

D. Whole blood, including items and services required in the collection, storage, and administration thereof, when ordered by a licensed physician and is not available to the patient from other sources.

Subp. 19. Mental health centers. "Mental health centers" are centers currently receiving grant-in-aid who are operating in accordance with parts 9520.0010 to 9520.0230. Services provided by mental health centers must be provided under the direction of a psychiatrist licensed to practice medicine in the United States or Canada or a licensed consulting psychologist, currently enrolled as an eligible provider under the medical assistance program. The MAPDP includes mental health center services provided to residents of long-term care facilities only if the attending physician assisted the development of the plan of treatment and periodically reviews that plan.

Subp. 20. Abortions. The cost of abortion services shall be included only when the conditions under items A, B, and C are met:

A. The abortion is necessary to prevent the death of the mother. The cost of the abortion shall be covered only if the documentation in subitems (1) and (2) accompanies the provider's invoice to the state agency:

(1) the signed written statement of two physicians that it was their professional judgment that the abortion was necessary to prevent the death of the mother; and

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(2) the signed written statement of the recipient that she voluntarily consented to the abortion. In the event that the recipient is physically or legally incapable of providing informed consent, consent may be obtained as is otherwise provided by law.

B. The abortion is to terminate a pregnancy which is the result of a sexual assault. The cost of the abortion shall be covered only if a report of the assault was made to a valid law enforcement agency within 48 hours of the time the assault occurred and a signed statement from the law enforcement agency accompanies the provider's invoice to the state agency. In the event the recipient was physically unable to make the report within 48 hours of the assault, the report must have been made within 48 hours after the recipient became physically able to make the report.

The statement of the law enforcement agency shall include:

(1) the name of the victim;

(2) the date of the alleged incident;

(3) the date the report was made to the law enforcement agency;

(4) the name and address of the person who signed the report to the law enforcement agency; and

(5) a statement by the law enforcement agency that the report alleges at least one of the following:

(a) the circumstances existing at the time of the assault caused the recipient to have a reasonable fear of imminent great bodily harm to herself or to another;

(b) the assailant was armed with a dangerous weapon or an article used or fashioned in a manner which led the recipient to reasonably believe it to be a dangerous weapon, and used or threatened to use the weapon or article to cause the complainant to submit;

(c) the assailant caused personal injury to the complainant and used force or coercion to accomplish sexual penetration; or

(d) the assailant was aided or abetted by one or more accomplices and either an accomplice used force or coercion to cause the recipient to submit, or an accomplice was armed with a dangerous weapon or an article used or fashioned in a manner to lead the complainant reasonably to believe it to be a dangerous weapon and used or threatened to use the weapon or article to cause the recipient to submit.

The provider's invoice shall also be accompanied by a statement, signed by the recipient, that her pregnancy resulted from the sexual assault reported, and a statement, signed by the recipient's physician, that in the physician's opinion the length of the pregnancy at the time of the abortion was not inconsistent with the recipient's statement.

C. The abortion is to terminate a pregnancy which is the result of incest. The cost of the abortion shall be covered only if a report of incest was made to a valid law enforcement agency prior to the time of the abortion and a signed statement from the law enforcement agency accompanies the provider's invoice to the state agency. The statement shall include:

(1) the name of the victim;

(2) the date of the alleged incident;

(3) the date the report was made to the law enforcement agency;

(4) the name and address of the person who signed the report to the law enforcement agency; and

(5) a statement by the law enforcement agency that the name of the relative who allegedly committed incest with the victim appears in its report.

The provider's invoice shall also be accompanied by a statement, signed by the recipient, that her pregnancy resulted from the incest reported, and a statement, signed by the recipient's physician, that in the physician's opinion the length of the pregnancy at the time of the abortion was not inconsistent with the recipient's statement.

D. For the purposes of this subpart only, the following definitions apply:

(1) "Abortion services" means medical service performed for the purpose of terminating a pregnancy. This shall not be construed to include drugs or devices which prevent implantation of the fertilized ovum, or medical procedures necessary for the termination of an ectopic pregnancy.

(2) "Assailant" means a person who allegedly committed the sexual assault reported to the law enforcement agency.

(3) "Incest" means sexual intercourse with another nearer in kin than first cousin, of the whole or half-blood.

(4) "Valid law enforcement agency" means an agency charged under applicable law with enforcement of the general penal statutes of the United States, or of any state or local jurisdiction.

9500.1470 [Emergency] CAPITATION POLICIES.

Subpart 1. Rates. Capitation rates must be developed on a historical cost basis. Base rates rates must determined by calculating a county average per capita cost. Presuming increased efficiency through provider-managed utilization, the actual rate offered (contractual rate) must be a specified percentage of the county average per capita cost.

The historical cost base of the rates must be fiscal year 1982 adjusted forward to the implementation year. This adjustment must be the per capita cost increase based on Department of Human Services projections (13.9 percent for noninstitutional, 15.0 percent for institutional enrollees), taking into account all legislative changes. Adjustments must be made for 1984 legislative action only if changes affect fiscal year 1985 payments.

Rates must be adjusted on a state fiscal year basis, July 1 to June 30. The annual increase to each capitation rate must be the maximum overall service unit increase as prescribed in Minnesota Statutes, section 256.966. If an annual increase is not prescribed in law for the 1986-1987 biennium, an equivalent factor must be calculated by the commissioner.

Subp. 2. Risk sharing arrangements. In addition to the capitation rate, the Department of Human Services shall provide two types of risk-sharing:

A. aggregate loss-sharing; and

B. individual stop-loss for catastrophic illness cases.

Subp. 3. Aggregate loss-sharing. Under aggregate loss-sharing, the Department of Human Services and Medicaid health plan shall share the loss if the allowable costs exceed the aggregate payment provided through the capitation. The MAPDP is intended to demonstrate the shifting of financial risk from the Department of Human Services to the Medicaid health plans, and aggregate loss-sharing shall be phased out over the three-year implementation period, under the following arrangement:

A. AFDC = (90 percent capitation):

(1) year 1, loss-share 50-50 up to 100 percent;

(2) year 2, loss-share 50-50 up to 100 percent; and

(3) year 3, no loss-sharing.

B. Aged, blind, disabled = (95 percent capitation):

(1) year 1, loss-share 50-50 up to 115 percent;

(2) year 2, loss-share 50-50 up to 105 percent; and

(3) year 3, no loss-sharing.

Risk-sharing expenses must only be applied to the aggregate cost of claims for services rendered directly to enrollees. For purposes of this policy, services rendered directly shall include services provided face to face with the enrollee, consultations with the enrollee's representative, or activities resulting in telephone contact with the enrollee.

Subp. 4. Individual stop-loss coverage. Stop-loss coverage must be provided for 80 percent of the cost of hospital claims exceeding $15,000 for AFDC enrollees and $30,000 for the aged, blind, or disabled enrollees and over 90 days of nursing home care or equivalent home health or personal care attendant services. For individual stop-loss, claims must be calculated according to medical assistance allowable charges.

This policy does not affect providers' opportunity to seek alternative care grants. When alternative care grants are awarded, stop-loss coverage must terminate because the cost of care shall be provided through the grant. This applies to personal care attendant services and home health care services. Individual stop-loss coverage must remain in place during the three years of the demonstration. Stop-loss coverage is that amount the Department of Human Services will pay in excess of capitation rates under the following circumstances.

Medicaid health plans may choose not to take part in the DHS stop-loss program. In order to choose another form of stop-loss coverage, the organization shall assure that:

A. there is an adequate financial reserve separate from operating funds to cover catastrophic liabilities;

B. not more than 30 percent of the organization's operating budget is medical assistance related; and

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C. the Medicaid health plan waives the right of 90-day termination of contract to be replaced by 180-day termination notice.

The capitation rate must be adjusted to include the cost of the Department of Human Services stop-loss, however additional costs of the purchasing private reinsurance must not be covered in the capitation nor be subject to cost-sharing.

9500.1471 [Emergency] PROVIDER CRITERIA.

Subpart 1. Standards. Criteria for provider participation in the MAPDP have been developed to ensure a minimum set of operating standards for Medicaid health plans. Part 9500.1471 is designed to encourage provider participation in the program and to uphold the existing quality of health care in the demonstration counties. These criteria form the basis for the contractual relationship between the Department of Human Services and the Medicaid health plans.

Subp. 2. Service array. Medicaid health plans shall be encouraged to serve as many medical assistance eligible populations as possible. A Medicaid health plan may design services for a single population limited to aged, blind, or disabled. If a plan elects to serve AFDC, it must serve at least one other medical assistance population.

Each Medicaid health plan shall provide or ensure provision of the full array of medical assistance benefits and services as set forth in part 9500.1469 [Emergency], subpart 1, to its enrollees.

With the exception of emergency services, the Medicaid health plan shall not be liable for payment for unauthorized services rendered outside of plan.

There shall be no copayments or deductibles charged to medical assistance consumers enrolled in a MAPDP.

Medicaid health plans may either be for profit or not for profit.

Subp. 3. Contractual arrangements. The Medicaid health plan's written contract with the Department of Human Services must ensure the provision of services to the selected medical assistance populations and ensure understanding of and compliance with all of the provider criteria for participation in the project.

Each Medicaid health plan shall demonstrate formal contractual arrangements with major providers to meet the service needs of its enrolled medical assistance population.

In the Medicaid health plan contract with the Department of Human Services there shall be a 90-day termination notice provision for either party. Also notification of termination of contract must be given to enrollees in plan not less than 30 days prior to cancellation. Responsibility for this notification shall be determined individually in each Medicaid health plan contract with the Department of Human Services.

Subp. 4. Membership. Each Medicaid health plan shall demonstrate capacity for servicing new members or enrollees.

The contract between the Department of Human Services and each Medicaid health plan must specify maximum and minimum number of enrollees based on physical and financial capabilities of Medicaid health plans.

Each Medicaid health plan shall accept all Medicaid eligible applicants wishing to enroll in its program, from the population categories it is targeted to serve regardless of health condition, within the enrollment capacity.

Subp. 5. Financial requirements. Each Medicaid health plan with Department of Human Services contracts shall be accountable for fiscal management control over the programs it sponsors or delivers.

Each Medicaid health plan shall demonstrate the capability to absorb losses either through a reserve fund or other mechanism agreed upon by the providers within each Medicaid health plan involved.

At the time of contracting with the Department of Human Services, each Medicaid health plan shall have a plan developed and approved for transferring enrollees to other delivery arrangements in the event of insolvency.

The Department of Human Services shall be held harmless in case of insolvency of Medicaid health plans or subcontracting providers, or both, for payment of services provided while the plan was operational.

The Medicaid health plan shall accept capitation from the Department of Human Services as full payment for services.

Subp. 6. Risk capability. Each Medicaid health plan may share risk with other corporate entities or other subcontracting providers.

Each Medicaid health plan shall be expected to assume phased and increasing risk over the three-year period of the demonstration. Each Medicaid health plan shall be at full risk by the third year.

Subp. 7. Marketing plan. Each Medicaid health plan must provide, at the time of contracting with the Department of Human Services, information on marketing activities to be directed at the MAPDP target population, and must present all marketing materials for the Department of Human Services' approval. No marketing materials shall be disseminated without prior written approval from the Department of Human Services.

Subp. 8. Data-information requirements. Each Medicaid health plan shall provide necessary information and data to the Department of Human Services and Federal Health Care Financer Administration as set forth in the MAPDP contract to meet the project needs for:

A. administration;

B. payment;

C. quality assurance;

D. evaluation;

E. Health Care Financer Administration requirements; and

F. fraud and abuse detection.

Each Medicaid health plan shall make immediately available to the Department of Human Services upon demand of the Department of Human Services information on medical assistance related medical records and financial information for quality assurance and evaluation purposes and for instances of suspected fraud and abuse.

Each Medicaid health plan shall be responsible for information needs set forth at subparts 1 to 7.

Each Medicaid health plan shall agree to use the Minnesota Medicaid Information System to avoid duplication.

Each MAPDP Medicaid health plan shall be responsible for reporting to the Department of Human Services information detailed in the data-information matrix published in "Medicaid Prepayment Demonstration Project: Provider Education Booklet" (February 1984), issued by the Minnesota Department of Human Services, Bureau of Income Maintenance, Health Care Programs Division, Office of New Initiatives, 444 Lafayette Road, St. Paul, Minnesota 55101, which is incorporated by reference.

Subp. 9. Quality assurance. Each Medicaid health plan shall develop a quality assurance system for appropriate delivery of health and social services to the enrolled medical assistance population. Each Medicaid health plan shall be responsible for monitoring and determining its own systems and corrective actions to assure quality. The quality assurance system must be in place at the time of contracting with the Department of Human Services and must include documentation and appropriate review or conduct of:

A. All problem cases and a randomly selected review of all cases. Portions of case review shall be done by a peer and interdisciplinary procedure. The Department of Human Services may require further review of any case.

B. Utilization of service.

C. Sentinal events including mortality rates, adverse outcomes, generally preventable disease.

D. Institutionalization rates.

E. Unauthorized out-of-plan usage.

F. Medical care evaluations.

G. Medical records audits.

H. Provider and consumer grievance rates.

I. Independent enrollee satisfaction surveys.

Subp. 10. Enrollee grievance procedures. Each Medicaid health plan shall have a grievance procedure or complaint system which solves enrollee complaints. The grievance procedure must be an informal system with a determination made within seven calendar days from the date the plan receives a complaint, and a formal structure including written complaints and formal hearing arbitration, with a determination made within 30 calendar days from the date the plan receives a complaint.

The grievance procedure must be in writing. A copy must be provided and explained to each enrollee, in a language that is understandable to them.

If a consumer is dissatisfied with the response of the internal plan grievance procedure, the consumer may appeal through state procedures as provided by Minnesota Statutes, section 256.045.

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Subp. 11. Procedural changes. Any changes in the procedure must be consistent with the provisions in this part and must be reported to the recipient at least two weeks before implementation. The process and the written material shall be approved by the Department of Human Services prior to implementation.

Subp. 12. Medicaid health plan grievance procedures. Each Medicaid health plan shall record all complaints, actions, and results and report to the Department of Human Services semi-annually.

If a Medicaid health plan is dissatisfied with the actions of an enrollee they may notify the Department of Human Services. It shall be explained to the enrollee in writing, with a copy given to the enrollee, that this notification shall not result in a loss of eligibility or removal from the Medicaid health plan.

The Medicaid health plan must provide for a second medical opinion when requested by the enrollee or the Department of Human Services within the plan and comply with any recommendations made by the professional advisory committee of the Department of Human Services and the appeals referee in response to the external formal grievance procedure.

Subp. 13. Case management. At the time of contracting with the Department of Human Services, Medicaid health plans must demonstrate a case management system that shall contain:

A. individual needs assessment;

B. individual care plan development and implementation; and

C. evaluation, monitoring, and revision of individual care plans.

9500.1473 [Emergency] DOCUMENTATION.

Local agencies shall document the completion of requirements in parts 9500.1450 to 9500.1475 [Emergency] on forms prescribed by the Department of Human Services.

9500.1474 [Emergency] INTERAGENCY COORDINATION.

Local agencies, including local nursing services, local head start agencies, and local school districts, shall cooperate with other agencies which provide health services to children so that duplication of services is avoided.

Department of Human Services

Proposed Emergency Rules Governing Prior Authorization for Health Services and Second Surgical Opinion as a Condition for MA and GAMC Reimbursement

Notice of Intent to Adopt Emergency Rules

The State Department of Human Services proposes to adopt the above-entitled emergency rules to implement Minnesota Statutes, section 256.991, supp. 1983.

Persons interested in these rules have until 4:30 p.m. on September 28, 1984 to submit written comments. The proposed emergency rules may be modified if the modifications are supported by the data and views submitted to the agency and do not result in a substantial change in the proposed language. Written comments should be sent to:

Ann Grossman
Department of Human Services
Professional Services Section
Second Floor, Space Center Building
444 Lafayette Road
St. Paul, MN 55101
Telephone: 612/297-2380

Upon adoption of these emergency rules, this notice, all written comments received, and the adopted emergency rules will be delivered to the Attorney General and to the Revisor of Statutes for review as to form and legality.

Notice of the date of submission of the proposed emergency rule to the attorney general will be mailed to any person requesting to receive this notice. The Attorney General shall approve or disapprove the proposed emergency rule and any modifications on the tenth working day following the date of receipt of the proposed emergency rule from the agency.

The adopted emergency rules will not become effective without the Attorney General's approval and the Revisor of Statutes' certification of the rules' form. Emergency rules take effect five working days after approval by the Attorney General.

As required by the Administrative Procedures Act, Minnesota Statutes, chapter 14, these emergency rules shall be in

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

PROPOSED EMERGENCY RULES GOVERNING ADMINISTRATION OF THE MEDICAL ASSISTANCE PREPAID DEMONSTRATION PROJECT UNDER THE MEDICAL ASSISTANCE PROGRAM, MINNESOTA RULES, PARTS 9500.1450 TO 9500.1474 [EMERGENCY]

FINDINGS OF FACT AND CONCLUSIONS

Introduction

The above-entitled matter was published in the State Register on September 3, 1984 as proposed emergency rules pursuant to Minnesota Statutes, sections 256.911, and 256B.69 - 256B.70 (1982). After proper notice required by Minnesota Statutes, sections 14.29 - 14.36 (1982) was served upon all persons, associations, and other interested groups registered with the State Department of Human Services for that purpose, and after affording interested and affected persons an opportunity to submit written data and views within 20 days of the publication date, reviewing and considering the data and views, and determining that the above captioned rules are needed and reasonable, I find the following.

Before the official publication of the rule, the Department relied heavily on an advisory task force composed of representatives of the various groups to be affected by the rules. The task force and the Department were able to develop a consensus regarding most aspects of the rules.

Summary of Letters and Department Response

A. Comments on Services

Fourteen letters of comment have been received regarding the proposed rules. Ten letters commented on service delivery issues. The Minnesota Medical Association commented on the need to specify that all providers must have an agreement with a Medicaid Health Plan (MHP) in order to participate in the project under 9500.1469, Subparts 4 and 16. The Department contends that the current language stating that all licensed physicians are eligible to participate should remain unchanged, but section 9500.1470 should be revised as follows to respond to the above comment: "Subpart 1 Rates. In designated demonstration areas, all MA payments for services included in the project will be paid through contract with the Medicaid Health Plan or county umbrella organization".

Related to the above comment the Minnesota Medical Association pointed out that Subpart 2 implies that all hospitals are eligible to participate without the necessary agreement with an MHP. To clarify this statement, the Department has amended line 27 to read "upon completion of an agreement with a particular MHP or county umbrella organization".

Additional comments were made by the Minnesota Medical Association on 9500.1469. In Subpart 17 (EPSDT) it is implied that the individual provider and not the MHP is responsible for EPSDT reporting. The Department, therefore, changes the word "provider" in line 4 to "MHP". MMA states that Subpart 5(c) should delete the reference to opthalmalogists. The Department agrees that opthalmalogists are covered under physicians and has made the requested change. In Subpart 9, the deletion of "the most cost-effective" is requested as it is unnecessary to state this. The Department stands by the current language as it states the Department's general endorsement of cost-effective medical practice. Additional comments to this section relate to emergency services. First, the MMA questions the inclusion of emergency care under the physician service section. Second, emergency services, as defined in Subpart 18, only includes inpatient hospital services. The Department agrees that the rule's present language should be clarified. Therefore, the reference to emergency services in Subpart 4 is deleted and to Subpart 18 physician services are added.

The Minnesota Dental Association requests the addition of a statement to Subpart 5 to the effect that all of the listed practitioners are eligible to participate in the MAPDP. The Department feels that the current language states this.

Two letters request that 9500.1469, Subpart 3 be altered to specify the long term care (LTC) policies under which MAPDP will operate. The rule in its present form refers to Rule 47 for covered LTC services. Since reimbursement is not specified, it is implied that the current policies apply (Rule 50, etc.). The MHP's LTC liability shall be specified in contract, The Department does not feel it is necessary to include specific MHP responsibilities in the rule.

The Minnesota Association of Health Care Financing (MAHCF) comments that the relationship between 9500.1469, Subpart 3, LTC services and Subpart 12, rehabilitative and therapeutic services in LTC facilities is unclear. The Department feels that Subpart 1 which states that all of the following services are covered under the MAPDP clearly states that rehabilitative and therapeutic are part of the project; hence, they are services to be delivered by MHPs or county umbrella organizations.

MAHCF also commented on the language in 9500.1469, Subpart 8, stating that the definition of a home health agency is out of place in this subpart. The Department feels that such a definition is appropriately included in this section.

Three letters noted the omission of rehabilitative and therapeutic services as services delivered by home health agencies. These were added under 9500.1469, Subpart 8(E).

The American Physical Therapy Association (APTA) suggested the addition of the physical therapy independent practitioner under 9500.1469, Subpart 5. The Department feels this is not necessary as such practitioners are dealt with under Subpart 13. APTA also suggested the addition of the independent physical therapy office under subpart 7, "Clinic Services". These offices are also covered under Subpart 13.

With regard to Subpart 13, one letter noted that it was unclear as to whether or not care provided to individuals in their homes by independent rehabilitative practitioners was covered under the project. The subpart does not specify the settings in which these services are covered and, therefore, implies that services in the home are covered.

Three letters suggested the inclusion of the word "maintain" in Subparts 9 and 14 of 9500.1469 as the function of rehabilitative therapy and medical supplies are not only to upgrade, but to maintain a person's level of physical functioning. These sections were revised to add the word "maintain".

Three letters questioned the qualification on specialized rehabilitative therapies in LTC facilities, 9500.1469, Subpart 12(D) which requires a reasonable medical expectation of improvement. The intent of the rule is to limit MA payment to services which will improve the patient's condition and, therefore, the Department has not amended the rule. The Department's position is supported by a letter from the American Physical Therapy Association which endorsed our definition of specialized rehabilitative therapies.

Two letters noted that the language in 9500.1469, Subpart 12, requiring on-site supervision of support personnel by a qualified physical therapist was too restrictive. The commentors refer the Department to the recently adopted Rules of the Board of Medical Examiners of the Physical Therapy Council. The Department's rule governs provider payment, not the scope of practice of individual practitioners. Thus, the Department chooses to cover services delivered by support personnel only in the circumstances specified in the rule.

Three letters questioned the inclusion of the phrase "when medically necessary" in Subpart 14(b) of 9500.1469. The Department agrees that it is inappropriate to single out psychological services and, therefore, deletes this phrase. Since all MA covered services relate to medical necessity, the phrase was inserted instead in line 12 to read:

"Rehabilitation agency services" are those <u>medically necessary</u> services provided by ..."

One letter sought clarification of the coverage of personal care attendant services, since these services are described as covered under 9500.1469, Subpart 18, yet in 9500.1454, Subpart 2, persons receiving these services are described as not eligible for the project. These services are correctly described as part of the project in Subpart 18, as MHPs or county umbrella organizations must provide these services as needed to

enrollees. However, the Department agrees that 9500.1454, Subpart 2, needs clarification. Persons currently on the personal care attendant program will not be included in the project. Persons who are already part of the project, who find they are in need of these services, will receive them under the project. At the time of rate cell redetermination, the latter group would become ineligible for the project. Insertion of the word "currently" in Subpart 2 should clarify this.

One letter noted the omission of three services under 9500.1469 including services for children with handicaps, hearing aids and glasses. The Department agrees that these services should be spelled out in the rule. Services for children with handicaps was added as section E under Subpart 18. Hearing aids were added to Subpart 9, section C. Glasses were added to Subpart 5, section C.

One letter recommended the addition of nutritional supplements to 9500.1469, Subpart 16, Pharmacy Services. The Department has amended this section to include this reference.

One letter questioned whether or not private duty nursing services were available in ICF/MRs. The Department's response is: For a person who is in need of skilled nursing the ICF/MR would not be an appropriate care setting.

One letter pointed out that independent physical therapists referred to in Subpart 13 are not presently being certified by the Minnesota Department of Health as stated in the rule. The Department verified with the MDH that the federal government certifies these practitioners after Health Department review. The wording in lines 35 and 36 was, therefore, changed to read "... and has been federally certified as an independent practitioner through the Minnesota Department of Health".

The Mental Health Association (MHA) requested the inclusion of detailed specifications for delivery of mental health services. Another letter supported this position by requesting some language relating to quality of services and the inclusion of coverage for Rule 29 clinics. Under the MAPDP, all mental health services currently covered under the MA program will be covered with more flexibility for alternative delivery than exists in the current fee-for-service system. Thus, participating provider plans could subcontract or refer clients to Rule 29 clinics. The mental health specifications referred to by MHA will be made contractually binding on participating plans. This should address the quality of care issue raised by the above comment. The Department feels that these specifications represent a substantial change from the rule as published. However, for the sake of clarity, we have amended 9500.1469, Subpart 19, by changing the heading to "Mental Health Services" with two subheadings:

A. Mental Health Centers

B. Other Mental Health Services must be provided by participating MHPs and county umbrella organizations as specified in contract.

A letter from the Minnesota Psychologists in Private Practice noted that the definition of psychologist in Subpart 5(D) is inaccurate and suggested another. Hence, Subpart 5(D) was amended to include the suggested definition. Subpart 14(B) was also amended consistent with the new definition.

B. Comments on Case Management

Three letters commented on case management. One questioned the definition of case management in 9500.1450 suggesting that an interdisciplinary team could also be responsible for case management. The definition was altered to include this reference. Two letters voiced a concern that case management as described in 9500.1469, Subpart 13, was too general and requested more detailed specifications. The Department will include detailed case management specification in our contracts with the MHPs and chooses not to include these in the rule.

C. Comments on Free Choice of Provider

Three letters recommended that specific counties not be mentioned in 9500.1460 so that the rule may be applicable to any county interested in participating. The Department agrees and has amended lines 8 and 9 to now read: "The counties acting as umbrella organizations for any of the covered MA services shall ensure..."

Three letters questioned the implications of stating in that same section that the majority of providers in the county should be included. Although it is the Department's goal that MAPDP include the majority of providers, this is not guaranteed. We have, therefore, changed the wording in this section to read: "... by including a sufficient number of providers..."

One letter requested the inclusion of the criteria for suspension of fee-for-service as outlined in the protocol in this section. The Department agrees that its inclusion is necessary and has inserted these as Subpart 2 in this section. The Department contends that this is not a substantial change as these criteria are part of the project protocol which was developed through a public committee process.

One letter noted the omission of two of the excluded populations as also outlined in the protocol. These two groups were added under 9500.1454 as Subparts 3 and 4.

Subpart 3. Current residents of state hospitals.
Subpart 4. Refugees who are currently recipients of the Refugee Assistance Program.

D. Comment on Provider Participation

One letter sought clarification of "major provider" in 9500.1471, Subpart 3. The word major was, therefore, stricken from the rule. The Department will specify to MHPs during the MHP approval process, the required contractual arrangements. This letter also questioned the "upon demand" phrasing in Subpart 8 of this section, referring to data information requirements. The Department agrees that the wording should be changed and has amended line 23 to read "... to the DHS after required notice..." This wording is consistent with statute.

One letter suggests that there may be criteria developed by counties (e.g. geographic area) in addition to those specified in 9500.1471, Subpart 4 for enrolling consumers in MHPs. The Department has added the words "or geographic areas" to line 12.

Another letter requested that the "peer and interdisciplinary procedure" specified in 9500.1471, Subpart 9, be defined as peer review by providers with the same professional training. The Department feels that the interdisciplinary requirement specified in the rule addresses the need to include different types of providers in quality assurance review and does not see the need for additional definition.

E. Comments on Rate Policies

Seven letters commented on section 9500.1470 "Capitation Policies". One suggested that individual providers should be informed of the portion of the capitation rate allocated to a particular service and that we add a statement to Subpart 1 requiring the Department to do this. The Department has and will continue to make this information available to providers upon request. It is not the intent of the MAPDP to allocate a portion of the capitation rate to a particular service. It is up to individual providers to negotiate a fair rate. We, therefore, choose not to include this requirement in the rule.

One letter suggested that Subpart 4 be altered to allow flexibility in the risk sharing arrangements and in Subpart 5 individual stop loss coverage. The Department agrees that we need to allow for necessary changes in these arrangements and has, therefore, inserted the following phrase in both subparts: "unless otherwise specified in the contract between the State and the Medicaid Health Plan".

One letter requested the addition of ICF/MR care to line 8, Subpart 4, as nursing home care alone is not sufficient to include persons entering ICF/MRs. This was done. Another was critical of Part 9500.1470 for lack of comprehensiveness in including project policies. Specifically, the MHPs responsibility for the first 90 days of institutional care was excluded. This is implied in Subpart 4 which outlines the Department's financial liability for excess costs. One letter noted the omission of specific DHS stop-loss coverage. The Department feels this is clearly defined in Subpart 4.

One letter asked that specific rates be included in the rule. The intent of the rule is to govern general policies. Specific capitation rates will be contractually specified and are inappropriate in the rule.

F. Comments on Client Issues

One letter voiced a desire for more specificity in the marketing restrictions on MHPs. The Department will deal with these restrictions in MHP contracts and not by rule. Another letter requested marketing plans

specific to the mentally retarded populations. The special marketing/educational needs of the mentally retarded will be addressed, but the Department feels it is inappropriate to include these in the rule.

Two letters commented on grievance procedures. 9500.1471, Subpart 10. One requested "a stepped-up review by the State, rather than the current, lengthy appeal process. Such a stepped-up review will be arranged for under the project. However, the function of this particular subpart is to delineate the grievance procedures required of participating MHPs. A second letter requested a provider grievance procedure. It is not the Department's function to handle provider grievances, particularly, for subcontracting providers with whom we have no direct relationship. However, HCFA will be surveying providers to ascertain satisfaction with the project.

One letter requested the inclusion of a second opinion as a quality assurance requirement under 9500.1471, Subpart 9. A second opinion will be required and specified in the MHP contract. However, the Department does not wish to add it to the rule, as this portion of the rule was based on provider criteria as approved by the project advisory committees and a second opinion was not one of the original criteria.

One letter requested the insertion of a qualifying phrase in 9500.1471, Subpart 2, lines 20 - 21, noting that copayments or deductibles could be charged for non-MA covered services. The Department will not allow copayments or deductibles charged for MA covered services or for services used as substitutes for MA covered services. However, to services which are neither, (e.g. fitness classes, infant car seats), a copayment may be applied. Hence, the wording of the rule was changed to clarify this.

One letter commented that not only the client, but parent or guardian could request services, referring to 9500.1469, Subpart 7. As this particular reference refers to family planning services, the request for services must originate with the client.

G. Definitional Comments

One letter objected to the term "mental diseases" in 9500.1469, Subpart 2, lines 15 - 16. The reference here is to institutions for mental disease. The wording must remain as it is for the sake of clarity.

Referring to that same part, Subpart 8, one letter requested the use of "his and hers" rather than "his" only. The Department had considered such language, but felt it was awkward, opting instead for "his" only, which legally signifies both male and female.

One letter noted in in 9500.1451, Subpart 2, that "prepaid reimbursement system" should more correctly be termed as "prepaid payment system". The Department agrees and has amended line 35 to read so.

Two letters noted that the word "prescribed" in 9500.1469, Subpart 12(A), 13(C), and 14(D) should be changed to "ordered" to make it consistent with statutory language. These subparts were amended accordingly.

One letter suggested that the term "malformed body member" in 9500.1469, Subpart 9, should be replaced with a more updated one. The Department has changed the wording of this section to read: "or to improve a physical impairment or maintain the functioning of the affected body part".

Now, therefore, it is ordered that, in light of the fact that the need for and reasonableness of this rule has been demonstated, the emergency rules, as amended, identified as MN Rules 9500.1450 to 9500.1474 (Emergency), governing administration of the MA prepaid demonstration project under the MA program and shall become effective October 29, 1984.

Dated: October 8, 1984

State of Minnesota
Department of Human Services



LEONARD W. LEVINE
Commissioner

CONCLUSIONS

I hereby conclude that:

1. The Commissioner has statutory authority to promulgate these rules.

2. Proper notice of the Department's intent to adopt the proposed above-captioned temporary rules was given as required by law, and all interested persons were afforded an opportunity to submit data and views on the proposed temporary rules.

3. All modifications made to the proposed temporary rule are supported by the data and views submitted to the Department, and are not substantial changes.

4. The temporary rules, as modified, are necessary and reasonable.

5. Any duplication in these rules of language contained in Minnesota Statutes is crucial to the ability of persons affected by the rules to comprehend their meaning and effect.

6. The Department has complied with all applicable provisions of law and rule in the promulgation of these rules.

7. If any finding or part of a finding, above, is property characterized as a conclusion, it is adopted as a conclusion.

Dated: October 8, 1984

STATE OF MINNESOTA

LEONARD W. LEVINE

Commissioner of Human Services

IN THE MATTER OF THE PROPOSED ADOPTION OF RULES OF THE STATE OF MINNESOTA DEPARTMENT OF HUMAN SERVICES GOVERNING ADMINISTRATION OF THE MEDICAL ASSISTANCE PREPAID DEMONSTRATION PROJECT UNDER THE MEDICAL ASSISTANCE PROGRAM, MINNESOTA RULES, PARTS 9500.1450 - 9500.1474 (EMERGENCY).

STATEMENT OF COMPLIANCE WITH RULEMAKING PROCEDURES

I, Special Assistant Attorney General, Elizabeth Cutter do hereby declare that I have examined the rules and all related documents and that, based on my examination and my personal familiarity with the applicable procedures, the Administrative Procedures Act, the rules of the Office of Administrative Hearings, and the rules of the Attorney General have been followed. Any exceptions are noted below.

Elizabeth Cutter

Special Assistant Attorney General

Dated: October 8, 1984