together with the available legal description by government tract, insofar as possible; (2) the number of linear feet of shoreline in each tract, together with a general description of that shoreline, whether it is rocky, sandy, or swampy, or some other descriptive system that generally describes the shoreland; (3) the acreage of each tract; (4) a general description of the surface of each tract, including topography and the predominant vegetative cover for each tract and any known unique surface features, such as areas of virgin and other old growth timber; and (5) using available real estate market value information and accepted real estate valuation techniques, assign estimates of the value for each tract, exclusive of minerals and mineral interests, using each of the real estate valuation techniques adopted for the inventory. For the purposes of this section, "state-owned land" is defined as any class of state-owned land, whether it is granted land such as school, university, swampland, or internal improvement, or whether it is tax-forfeited, acquired, or state-owned land of any other classification. At the request of the university, the commissioner of natural resources shall promptly provide the university with all published maps, whether federal, state, or county, together with a descriptive list of state-owned land in the area, using available legal descriptions, forest inventories, and other factual information, published data, and photographs that are necessary for the university's inventory. From these maps, lists, data, and other information, the university is requested to prepare a report of its inventory. The legislature requests that the University of Minnesota submit the report to the legislature by January 15, 2002.

Sec. 22. **EFFECTIVE DATE.**

Section 20 is effective the day following final enactment.

Presented to the governor May 11, 2000

Signed by the governor May 15, 2000, 10:47 a.m.

CHAPTER 474—H.F.No. 3409

An act relating to human services; modifying provisions in continuing care services for persons with disabilities; amending Minnesota Statutes 1998, sections 62D.09, subdivision 8; 252.28, by adding a subdivision; and 256B.0625, subdivision 19a; Minnesota Statutes 1999 Supplement, sections 62Q.73, subdivision 2; 245.462, subdivision 4; 245.4871, subdivision 4; 256B.0625, subdivision 19c; 256B.0627, subdivisions 1, 5, 8, and 11; 256B.501, subdivision 8a; 256B.5011, subdivision 2; 256B.5013, subdivision 1, and by adding subdivisions; and 256B.77, subdivision 8.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 1998, section 62D.09, subdivision 8, is amended to read:

Subd. 8. Each health maintenance organization shall issue a membership card to its enrollees. The membership card must:

(1) identify the health maintenance organization;

(2) include the name, address, and telephone number to call if the enrollee has a complaint;

(3) include the telephone number to call or the instruction on how to receive authorization for emergency care; and

(4) include one of the following:

(i) the telephone number to call to appeal to or file a complaint with the commissioner of health; or

(ii) for persons enrolled under section 256B.69, 256B.77, 256D.03, or 256L.12, the telephone number to call to file a complaint with the ombudsperson designated by the commissioner of human services under section 256B.69 or the office of the ombudsman for mental health and mental retardation under section 256B.77 and the address to appeal to the commissioner of human services. The ombudsperson shall annually provide the commissioner of health with a summary of complaints and actions taken.

Sec. 2. Minnesota Statutes 1999 Supplement, section 62Q.73, subdivision 2, is amended to read:

Subd. 2. **EXCEPTION.** (a) This section does not apply to governmental programs except as permitted under paragraph (b). For purposes of this subdivision, "governmental programs" means the prepaid medical assistance program, the MinnesotaCare program, the prepaid general assistance medical care program, the demonstration project for people with disabilities, and the federal Medicare program.

(b) In the course of a recipient's appeal of a medical determination to the commissioner of human services under section 256.045, the recipient may request an expert medical opinion be arranged by the external review entity under contract to provide independent external reviews under this section. If such a request is made, the cost of the review shall be paid by the commissioner of human services. Any medical opinion obtained under this paragraph shall only be used by a state human services referee as evidence in the recipient's appeal to the commissioner of human services under section 256.045.

(c) Nothing in this subdivision shall be construed to limit or restrict the appeal rights provided in section 256.045 for governmental program recipients.

Sec. 3. Minnesota Statutes 1999 Supplement, section 245.462, subdivision 4, is amended to read:

Subd. 4. **CASE MANAGEMENT SERVICE PROVIDER.** (a) "Case management service provider" means a case manager or case manager associate employed by the county or other entity authorized by the county board to provide case management services specified in section 245.4711..

(b) A case manager must:

(1) be skilled in the process of identifying and assessing a wide range of client needs;

(2) be knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) have a bachelor's degree in one of the behavioral sciences or related fields including, but not limited to, social work, psychology, or nursing from an accredited college or university. ~~A case manager must have at least 2,000 hours of supervised experience in the delivery of services to adults with mental illness, must be skilled in the process of identifying and assessing a wide range of client needs, and must be knowledgeable about local community resources and how to use those resources for the benefit of the client~~ or meet the requirements of paragraph (c); and

(4) meet the supervision and continuing education requirements described in paragraphs (d), (e), and (f), as applicable.

~~(b) Supervision for a case manager during the first year of service providing case management services shall be one hour per week of clinical supervision from a case management supervisor. After the first year, the case manager shall receive regular ongoing supervision totaling 38 hours per year, of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The remainder may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours. Clinical supervision must be documented in the client record.~~

~~(c) A case manager with a bachelor's degree who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in mental illness and mental health services annually.~~

~~(d) A case manager with a bachelor's degree but without 2,000 hours of supervised experience described in paragraph (a), must complete 40 hours of training approved by the commissioner covering case management skills and the characteristics and needs of adults with serious and persistent mental illness.~~

~~(e)~~ (c) Case managers without a bachelor's degree must meet one of the requirements in clauses (1) to (3):

(1) have three or four years of experience as a case manager associate as defined in this section;

(2) be a registered nurse without a bachelor's degree and have a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; or

(3) be a person who qualified as a case manager under the 1998 department of human service ~~federal~~ waiver provision and meet the continuing education and mentoring requirements in this section.

(d) A case manager with at least 2,000 hours of supervised experience in the delivery of services to adults with mental illness must receive regular ongoing supervision and clinical supervision totaling 38 hours per year of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The remaining 26 hours of supervision may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours. Clinical supervision must be documented in the client record.

(e) A case manager without 2,000 hours of supervised experience in the delivery of services to adults with mental illness must:

(1) receive clinical supervision regarding individual service delivery from a mental health professional at least one hour per week until the requirement of 2,000 hours of experience is met; and

(2) complete 40 hours of training approved by the commissioner in case management skills and the characteristics and needs of adults with serious and persistent mental illness.

(f) A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in mental illness and mental health services annually.

(g) A case manager associate (CMA) must:

(1) work under the direction of a case manager or case management supervisor ~~and must~~;

(2) be at least 21 years of age~~. A case manager associate must also~~;

(3) have at least a high school diploma or its equivalent; and

(4) meet one of the following criteria:

~~(1)~~ (i) have an associate of arts degree in one of the behavioral sciences or human services;

~~(2)~~ (ii) be a registered nurse without a bachelor's degree;

~~(3)~~ (iii) within the previous ten years, have three years of life experience with serious and persistent mental illness as defined in section 245.462, subdivision 20; or as a child had severe emotional disturbance as defined in section 245.4871, subdivision 6; or have three years life experience as a primary caregiver to an adult with serious and persistent mental illness within the previous ten years;

~~(4)~~ (iv) have 6,000 hours work experience as a nondegreed state hospital technician; or

~~(5)~~ (v) be a mental health practitioner as defined in section 245.462, subdivision 17, clause (2).

Individuals meeting one of the criteria in ~~clauses (1) to (4)~~ items (i) to (iv), may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in ~~clause (5)~~ item (v), may qualify as a case manager after three years of supervised experience as a case manager associate.

(h) A case management ~~associates~~ associate must meet the following supervision, mentoring, and continuing education requirements:

(1) have 40 hours of preservice training described under paragraph ~~(d) and~~ (e), clause (2);

(2) receive at least 40 hours of continuing education in mental illness and mental health services annually. ~~Case manager associates shall;~~ and

(3) receive at least five hours of mentoring per week from a case management mentor.

A "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision to one or more case manager associates. Mentoring may occur while providing direct services to consumers in the office or in the field and may be provided to individuals or groups of case manager associates. At least two mentoring hours per week must be individual and face-to-face.

~~(g)~~ (i) A case management supervisor must meet the criteria for mental health professionals, as specified in section 245.462, subdivision 18.

~~(h)~~ (j) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to adult immigrants with serious and persistent mental illness who are members of the same ethnic group as the case manager if the person:

(1) is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university;

(2) completes 40 hours of training as specified in this subdivision; and

(3) receives clinical supervision at least once a week until the requirements of this subdivision are met.

Sec. 4. Minnesota Statutes 1999 Supplement, section 245.4871, subdivision 4, is amended to read:

Subd. 4. **CASE MANAGEMENT SERVICE PROVIDER.** (a) "Case management service provider" means a case manager or case manager associate employed by the county or other entity authorized by the county board to provide case management services specified in subdivision 3 for the child with severe emotional disturbance and the child's family. ~~A case manager must have experience and training in working with children.~~

(b) A case manager must:

(1) have experience and training in working with children;

(2) have at least a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university or meet the requirements of paragraph (d);

~~(2) have at least 2,000 hours of supervised experience in the delivery of mental health services to children;~~

(3) have experience and training in identifying and assessing a wide range of children's needs; and

(4) be knowledgeable about local community resources and how to use those resources for the benefit of children and their families; and

(5) meets the supervision and continuing education requirements of paragraphs (e), (f), and (g), as applicable.

(c) ~~The~~ A case manager may be a member of any professional discipline that is part of the local system of care for children established by the county board.

(d) A case manager without a bachelor's degree must meet one of the requirements in clauses (1) to (3):

(1) have three or four years of experience as a case manager associate;

(2) be a registered nurse without a bachelor's degree who has a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; or

(3) be a person who qualified as a case manager under the 1998 department of human services waiver provision and meets the continuing education, supervision, and mentoring requirements in this section.

(e) ~~The~~ A case manager ~~shall~~ with at least 2,000 hours of supervised experience in the delivery of mental health services to children must receive regular ongoing supervision and clinical supervision totaling 38 hours per year, of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The ~~remainder~~ other 26 hours of supervision may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours.

~~(e)~~ (f) A case ~~managers with a bachelor's degree but~~ manager without 2,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbance must:

(1) begin 40 hours of training approved by the commissioner of human services in case management skills and in the characteristics and needs of children with severe emotional disturbance before beginning to provide case management services; and

(2) receive clinical supervision regarding individual service delivery from a mental health professional at least one hour each week until the requirement of 2,000 hours of experience is met.

(g) A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in severe emotional disturbance and mental health services annually.

~~(f)~~ (h) Clinical supervision must be documented in the child's record. When the case manager is not a mental health professional, the county board must provide or contract for needed clinical supervision.

~~(g)~~ (i) The county board must ensure that the case manager has the freedom to access and coordinate the services within the local system of care that are needed by the child.

~~(h) Case managers who have a bachelor's degree but are not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in severe emotional disturbance and mental health services annually.~~

~~(i) Case managers without a bachelor's degree must meet one of the requirements in clauses (1) to (3):~~

~~(1) have three or four years of experience as a case manager associate;~~

~~(2) be a registered nurse without a bachelor's degree who has a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; or~~

~~(3) be a person who qualified as a case manager under the 1998 department of human service federal waiver provision and meets the continuing education and mentoring requirements in this section.~~

(j) A case manager associate (CMA) must:

(1) work under the direction of a case manager or case management supervisor ~~and must~~;

(2) be at least 21 years of age. ~~A case manager associate must also~~;

(3) have at least a high school diploma or its equivalent; and

(4) meet one of the following criteria:

~~(1)~~ (i) have an associate of arts degree in one of the behavioral sciences or human services;

~~(2)~~ (ii) be a registered nurse without a bachelor's degree;

~~(3)~~ (iii) have three years of life experience as a primary caregiver to a child with serious emotional disturbance as defined in section 245.4871, subdivision 6, within the previous ten years;

~~(4)~~ (iv) have 6,000 hours work experience as a nondegreed state hospital technician; or

~~(5)~~ (v) be a mental health practitioner as defined in section 245.462, subdivision ~~17~~ 26, clause (2).

Individuals meeting one of the criteria in ~~clauses~~ ~~(1)~~ items (i) to ~~(4)~~ (iv) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in ~~clause~~ ~~(5)~~ item (v) may qualify as a case manager after three years of supervised experience as a case manager associate.

(k) Case manager associates must meet the following supervision, mentoring, and continuing education requirements;

(1) have 40 hours of preservice training described under paragraph ~~(e)~~ (f), clause (1)~~, and~~;

(2) receive at least 40 hours of continuing education in severe emotional disturbance and mental health service annually~~. Case manager associates shall~~; and

(3) receive at least five hours of mentoring per week from a case management mentor. A "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision to one or more case manager associates. Mentoring may occur while providing direct services to consumers in the office or in the field and may be provided to individuals or groups of case manager associates. At least two mentoring hours per week must be individual and face-to-face.

~~(k)~~ (l) A case management supervisor must meet the criteria for a mental health professional as specified in section 245.4871, subdivision 27.

~~(l)~~ (m) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to child immigrants with severe emotional disturbance of the same ethnic group as the immigrant if the person:

(1) is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or related fields at an accredited college or university;

(2) completes 40 hours of training as specified in this subdivision; and

(3) receives clinical supervision at least once a week until the requirements of obtaining a bachelor's degree and 2,000 hours of supervised experience are met.

Sec. 5. Minnesota Statutes 1998, section 252.28, is amended by adding a subdivision to read:

Subd. 3b. **OLMSTED COUNTY LICENSING EXEMPTION.** (a) Notwithstanding subdivision 3, the commissioner may license service sites each accommodating up to five residents moving from a 43-bed intermediate care facility for persons

with mental retardation or related conditions located in Olmsted county that is closing under section 252.292.

(b) Notwithstanding the provisions of any other state law or administrative rule, the rate provisions of section 256I.05, subdivision 1, apply to the exception in this subdivision.

Sec. 6. Minnesota Statutes 1998, section 256B.0625, subdivision 19a, is amended to read:

Subd. 19a. **PERSONAL CARE SERVICES.** Medical assistance covers personal care services in a recipient's home. To qualify for personal care services, recipients or responsible parties must be able to identify the recipient's needs, direct and evaluate task accomplishment, and provide for health and safety. Approved hours may be used outside the home when normal life activities take them outside the home and when, without the provision of personal care, their health and safety would be jeopardized. To use personal care services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Total hours for services, whether actually performed inside or outside the recipient's home, cannot exceed that which is otherwise allowed for personal care services in an in-home setting according to section 256B.0627. Medical assistance does not cover personal care services for residents of a hospital, nursing facility, intermediate care facility, health care facility licensed by the commissioner of health, or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the personal care services or forgoes the facility per diem for the leave days that personal care services are used. All personal care services must be provided according to section 256B.0627. Personal care services may not be reimbursed if the personal care assistant is the spouse or legal guardian of the recipient or the parent of a recipient under age 18, or the responsible party or the foster care provider of a recipient who cannot direct the recipient's own care unless, in the case of a foster care provider, a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met. Parents of adult recipients, adult children of the recipient or adult siblings of the recipient may be reimbursed for personal care services if they are not the recipient's legal guardian and are granted a waiver under section 256B.0627. Until July 1, 2001, and notwithstanding the provisions of section 256B.0627, subdivision 4, paragraph (b), clause (4), the noncorporate legal guardian or conservator of an adult, who is not the responsible party and not the personal care provider organization, may be granted a hardship waiver under section 256B.0627, to be reimbursed to provide personal care assistant services to the recipient, and shall not be considered to have a service provider interest for purposes of participation on the screening team under section 256B.092, subdivision 7.

Sec. 7. Minnesota Statutes 1999 Supplement, section 256B.0625, subdivision 19c, is amended to read:

Subd. 19c. **PERSONAL CARE.** Medical assistance covers personal care services provided by an individual who is qualified to provide the services according to

subdivision 19a and section 256B.0627, where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by the recipient under the fiscal agent option according to section 256B.0627, subdivision 10, or a qualified professional. "Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, or 245.4871, subdivision ~~26~~ 27; or a registered nurse as defined in sections 148.171 to 148.285. As part of the assessment, the county public health nurse will consult with the recipient or responsible party and identify the most appropriate person to provide supervision of the personal care assistant. The qualified professional shall perform the duties described in Minnesota Rules, part 9505.0335, subpart 4.

Sec. 8. Minnesota Statutes 1999 Supplement, section 256B.0627, subdivision 1, is amended to read:

Subdivision 1. **DEFINITION.** (a) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for private duty nursing shall be conducted by a registered private duty nurse. Assessments for home health agency services shall be conducted by a home health agency nurse. Assessments for personal care assistant services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county. A face-to-face assessment must include: a documentation of health status ~~assessment and~~, determination of need, evaluation of service ~~outcomes, collection of case~~ data effectiveness, identification of appropriate services ~~and~~, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, ~~obtaining~~ recommendation of service authorization, and consumer education. Once the need for personal care assistant services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. A face-to-face assessment for personal care services is conducted on those recipients who have never had a county public health nurse assessment. A face-to-face assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistant services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistant service. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service ~~outcomes~~ effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments for medical assistance home care services for mental retardation or related conditions and alternative care services for developmentally disabled home and community-based waivered recipients may be conducted by the county public health nurse to ensure coordination and avoid duplication. Assessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.

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

(c) "Home care services" means a health service, determined by the commissioner as medically necessary, that is ordered by a physician and documented in a service plan that is reviewed by the physician at least once every 62 days for the provision of home health services, or private duty nursing, or at least once every 365 days for personal care. Home care services are provided to the recipient at the recipient's residence that is a place other than a hospital or long-term care facility or as specified in section 256B.0625.

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

(e) "Personal care assistant" means a person who: (1) is at least 18 years old, except for persons 16 to 18 years of age who participated in a related school-based job training program or have completed a certified home health aide competency evaluation; (2) is able to effectively communicate with the recipient and personal care provider organization; (3) effective July 1, 1996, has completed one of the training requirements as specified in Minnesota Rules, part 9505.0335, subpart 3, items A to D; (4) has the ability to, and provides covered personal care services according to the recipient's care plan, responds appropriately to recipient needs, and reports changes in the recipient's condition to the supervising qualified professional; (5) is not a consumer of personal care services; and (6) is subject to criminal background checks and procedures specified in section 245A.04.

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

(g) "Responsible party" means an individual residing with a recipient of personal care services who is capable of providing the supportive care necessary to assist the recipient to live in the community, is at least 18 years old, and is not a personal care assistant. Responsible parties who are parents of minors or guardians of minors or

incapacitated persons may delegate the responsibility to another adult during a temporary absence of at least 24 hours but not more than six months. The person delegated as a responsible party must be able to meet the definition of responsible party, except that the delegated responsible party is required to reside with the recipient only while serving as the responsible party. Foster care license holders may be designated the responsible party for residents of the foster care home if case management is provided as required in section 256B.0625, subdivision 19a. For persons who, as of April 1, 1992, are sharing personal care services in order to obtain the availability of 24-hour coverage, an employee of the personal care provider organization may be designated as the responsible party if case management is provided as required in section 256B.0625, subdivision 19a.

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

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

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

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

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

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

Sec. 9. Minnesota Statutes 1999 Supplement, section 256B.0627, subdivision 5, is amended to read:

Subd. 5. **LIMITATION ON PAYMENTS.** Medical assistance payments for home care services shall be limited according to this subdivision.

(a) **LIMITS ON SERVICES WITHOUT PRIOR AUTHORIZATION.** A recipient may receive the following home care services during a calendar year:

(1) up to two face-to-face assessments to determine a recipient's need for personal care assistant services;

(2) one service update done to determine a recipient's need for personal care services; and

(3) up to five skilled nurse visits.

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

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

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

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

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

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

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

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

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

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

assessment, or conduct a home visit to assess the need and determine whether the change is appropriate.

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

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

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

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

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

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

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

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

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

(F) a reasonable amount of time for the provision of supervision by a qualified professional of personal care services.

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

(iii) The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner by the county public health nurse on forms specified by the commissioner. The home care rating shall be a combination of current assessment tools developed under sections 256B.0911 and 256B.501 with an addition for seizure activity that will assess the frequency and severity of seizure activity and with adjustments, additions, and clarifications that are necessary to reflect the needs and conditions of recipients who need home care including children and adults under 65 years of age. The commissioner shall establish these forms and protocols under this section and shall use an advisory group, including representatives of recipients, providers, and counties, for consultation in establishing and revising the forms and protocols.

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

(A) daily tube feedings;

(B) daily parenteral therapy;

(C) wound or decubiti care;

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

(E) catheterization;

(F) ostomy care;

(G) quadriplegia; or

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

(v) A recipient shall qualify as having Level I behavior if there is reasonable supporting evidence that the recipient exhibits, or that without supervision, observation, or redirection would exhibit, one or more of the following behaviors that cause, or have the potential to cause:

(A) injury to the recipient's own body;

(B) physical injury to other people; or

(C) destruction of property.

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

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

(A) unusual or repetitive habits;

(B) withdrawn behavior; or

(C) offensive behavior.

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

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

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

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

The commissioner may authorize:

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

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

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

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

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

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

(g) **APPROVAL OF HOME CARE SERVICES.** The commissioner or the commissioner's designee shall determine the medical necessity of home care services, the level of caregiver according to subdivision 2, and the institutional comparison according to this subdivision, the cost-effectiveness of services, and the amount, scope, and duration of home care services reimbursable by medical assistance, based on the assessment, primary payer coverage determination information as required, the service plan, the recipient's age, the cost of services, the recipient's medical condition, and diagnosis or disability. The commissioner may publish additional criteria for determining medical necessity according to section 256B.04.

(h) **PRIOR AUTHORIZATION REQUESTS; TEMPORARY SERVICES.** The agency nurse, the independently enrolled private duty nurse, or county public health nurse may request a temporary authorization for home care services by

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

(i) **PRIOR AUTHORIZATION REQUIRED IN FOSTER CARE SETTING.** Home care services provided in an adult or child foster care setting must receive prior authorization by the department according to the limits established in paragraph (a).

The commissioner may not authorize:

(1) home care services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules. ~~Requests for home care services for recipients residing in a foster care setting must include the foster care placement agreement and determination of difficulty of care~~;

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

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

(4) ~~home~~ personal care assistant and private duty nursing services when the number of foster care residents is greater than four unless the county responsible for the recipient's foster placement made the placement prior to April 1, 1992, requests that ~~home~~ personal care assistant and private duty nursing services be provided, and case management is provided as required in section 256B.0625, subdivision 19a; ~~or~~.

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

Sec. 10. Minnesota Statutes 1999 Supplement, section 256B.0627, subdivision 8, is amended to read:

Subd. 8. **SHARED PERSONAL CARE ASSISTANT SERVICES.** (a) Medical assistance payments for shared personal care assistance services shall be limited according to this subdivision.

(b) Recipients of personal care assistant services may share staff and the commissioner shall provide a rate system for shared personal care assistant services. For two persons sharing services, the rate paid to a provider shall not exceed 1-1/2 times the rate paid for serving a single individual, and for three persons sharing

services, the rate paid to a provider shall not exceed twice the rate paid for serving a single individual. These rates apply only to situations in which all recipients were present and received shared services on the date for which the service is billed. No more than three persons may receive shared services from a personal care assistant in a single setting.

(c) Shared service is the provision of personal care services by a personal care assistant to two or three recipients at the same time and in the same setting. For the purposes of this subdivision, "setting" means:

(1) the home or foster care home of one of the individual recipients; or

(2) a child care program in which all recipients served by one personal care assistant are participating, which is licensed under chapter 245A or operated by a local school district or private school~~.~~; or

(3) outside the home or foster care home of one of the recipients when normal life activities take the recipients outside the home.

The provisions of this subdivision do not apply when a personal care assistant is caring for multiple recipients in more than one setting.

(d) The recipient or the recipient's responsible party, in conjunction with the county public health nurse, shall determine:

(1) whether shared personal care assistant services is an appropriate option based on the individual needs and preferences of the recipient; and

(2) the amount of shared services allocated as part of the overall authorization of personal care services.

The recipient or the responsible party, in conjunction with the supervising qualified professional, shall arrange the setting and grouping of shared services based on the individual needs and preferences of the recipients. Decisions on the selection of recipients to share services must be based on the ages of the recipients, compatibility, and coordination of their care needs.

(e) The following items must be considered by the recipient or the responsible party and the supervising qualified professional, and documented in the recipient's health service record:

(1) the additional qualifications needed by the personal care assistant to provide care to several recipients in the same setting;

(2) the additional training and supervision needed by the personal care assistant to ensure that the needs of the recipient are met appropriately and safely. The provider must provide on-site supervision by a qualified professional within the first 14 days of shared services, and monthly thereafter;

(3) the setting in which the shared services will be provided;

(4) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting; and

(5) a contingency plan which accounts for absence of the recipient in a shared services setting due to illness or other circumstances and staffing contingencies.

(f) The provider must offer the recipient or the responsible party the option of shared or one-on-one personal care assistant services. The recipient or the responsible party can withdraw from participating in a shared services arrangement at any time.

(g) In addition to documentation requirements under Minnesota Rules, part 9505.2175, a personal care provider must meet documentation requirements for shared personal care assistant services and must document the following in the health service record for each individual recipient sharing services:

(1) permission by the recipient or the recipient's responsible party, if any, for the maximum number of shared services hours per week chosen by the recipient;

(2) permission by the recipient or the recipient's responsible party, if any, for personal care assistant services provided outside the recipient's residence;

(3) permission by the recipient or the recipient's responsible party, if any, for others to receive shared services in the recipient's residence;

(4) revocation by the recipient or the recipient's responsible party, if any, of the shared service authorization, or the shared service to be provided to others in the recipient's residence, or the shared service to be provided outside the recipient's residence;

(5) supervision of the shared personal care assistant services by the qualified professional, including the date, time of day, number of hours spent supervising the provision of shared services, whether the supervision was face-to-face or another method of supervision, changes in the recipient's condition, shared services scheduling issues and recommendations;

(6) documentation by the qualified professional of telephone calls or other discussions with the personal care assistant regarding services being provided to the recipient; and

(7) daily documentation of the shared services provided by each identified personal care assistant including:

(i) the names of each recipient receiving shared services together;

(ii) the setting for the shared services, including the starting and ending times that the recipient received shared services; and

(iii) notes by the personal care assistant regarding changes in the recipient's condition, problems that may arise from the sharing of services, scheduling issues, care issues, and other notes as required by the qualified professional.

(h) Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to personal care services apply to shared services.

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

Sec. 11. Minnesota Statutes 1999 Supplement, section 256B.0627, subdivision 11, is amended to read:

Subd. 11. **SHARED PRIVATE DUTY NURSING CARE OPTION.** (a) Medical assistance payments for shared private duty nursing services by a private duty nurse shall be limited according to this subdivision. For the purposes of this section, "private duty nursing agency" means an agency licensed under chapter 144A to provide private duty nursing services.

(b) Recipients of private duty nursing services may share nursing staff and the commissioner shall provide a rate methodology for shared private duty nursing. For two persons sharing nursing care, the rate paid to a provider shall not exceed 1.5 times the nonwaivered private duty nursing rates paid for serving a single individual who is not ventilator dependent, by a registered nurse or licensed practical nurse. These rates apply only to situations in which both recipients are present and receive shared private duty nursing care on the date for which the service is billed. No more than two persons may receive shared private duty nursing services from a private duty nurse in a single setting.

(c) Shared private duty nursing care is the provision of nursing services by a private duty nurse to two recipients at the same time and in the same setting. For the purposes of this subdivision, "setting" means:

(1) the home or foster care home of one of the individual recipients; or

(2) a child care program licensed under chapter 245A or operated by a local school district or private school; or

(3) an adult day care service licensed under chapter 245A.~~;~~ or

(4) outside the home or foster care home of one of the recipients when normal life activities take the recipients outside the home.

This subdivision does not apply when a private duty nurse is caring for multiple recipients in more than one setting.

(d) The recipient or the recipient's legal representative, and the recipient's physician, in conjunction with the home health care agency, shall determine:

(1) whether shared private duty nursing care is an appropriate option based on the individual needs and preferences of the recipient; and

(2) the amount of shared private duty nursing services authorized as part of the overall authorization of nursing services.

(e) The recipient or the recipient's legal representative, in conjunction with the private duty nursing agency, shall approve the setting, grouping, and arrangement of shared private duty nursing care based on the individual needs and preferences of the recipients. Decisions on the selection of recipients to share services must be based on the ages of the recipients, compatibility, and coordination of their care needs.

(f) The following items must be considered by the recipient or the recipient's legal representative and the private duty nursing agency, and documented in the recipient's health service record:

(1) the additional training needed by the private duty nurse to provide care to ~~several~~ two recipients in the same setting and to ensure that the needs of the recipients are met appropriately and safely;

(2) the setting in which the shared private duty nursing care will be provided;

(3) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting;

(4) a contingency plan which accounts for absence of the recipient in a shared private duty nursing setting due to illness or other circumstances;

(5) staffing backup contingencies in the event of employee illness or absence; and

(6) arrangements for additional assistance to respond to urgent or emergency care needs of the recipients.

(g) The provider must offer the recipient or responsible party the option of shared or one-on-one private duty nursing services. The recipient or responsible party can withdraw from participating in a shared service arrangement at any time.

(h) The private duty nursing agency must document the following in the health service record for each individual recipient sharing private duty nursing care:

(1) permission by the recipient or the recipient's legal representative for the maximum number of shared nursing care hours per week chosen by the recipient;

(2) permission by the recipient or the recipient's legal representative for shared private duty nursing services provided outside the recipient's residence;

(3) permission by the recipient or the recipient's legal representative for others to receive shared private duty nursing services in the recipient's residence;

(4) revocation by the recipient or the recipient's legal representative of the shared private duty nursing care authorization, or the shared care to be provided to others in the recipient's residence, or the shared private duty nursing services to be provided outside the recipient's residence; and

(5) daily documentation of the shared private duty nursing services provided by each identified private duty nurse, including:

(i) the names of each recipient receiving shared private duty nursing services together;

(ii) the setting for the shared services, including the starting and ending times that the recipient received shared private duty nursing care; and

(iii) notes by the private duty nurse regarding changes in the recipient's condition, problems that may arise from the sharing of private duty nursing services, and scheduling and care issues.

(i) Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to private duty nursing services apply to shared private duty nursing services.

Nothing in this subdivision shall be construed to reduce the total number of private duty nursing hours authorized for an individual recipient under subdivision 5.

Sec. 12. Minnesota Statutes 1999 Supplement, section 256B.501, subdivision 8a, is amended to read:

Subd. 8a. **PAYMENT FOR PERSONS WITH SPECIAL NEEDS FOR CRISIS INTERVENTION SERVICES.** Community-based crisis services authorized by the commissioner or the commissioner's designee for a resident of an intermediate care facility for persons with mental retardation (ICF/MR) reimbursed under this section shall be paid by medical assistance in accordance with the paragraphs (a) to (g).

(a) "Crisis services" means the specialized services listed in clauses (1) to (3) provided to prevent the recipient from requiring placement in a more restrictive institutional setting such as an inpatient hospital or regional treatment center and to maintain the recipient in the present community setting.

(1) The crisis services provider shall assess the recipient's behavior and environment to identify factors contributing to the crisis.

(2) The crisis services provider shall develop a recipient-specific intervention plan in coordination with the service planning team and provide recommendations for revisions to the individual service plan if necessary to prevent or minimize the likelihood of future crisis situations. The intervention plan shall include a transition plan to aid the recipient in returning to the community-based ICF/MR if the recipient is receiving residential crisis services.

(3) The crisis services provider shall consult with and provide training and ongoing technical assistance to the recipient's service providers to aid in the implementation of the intervention plan and revisions to the individual service plan.

(b) "Residential crisis services" means crisis services that are provided to a recipient admitted to an alternative, state-licensed site approved by the commissioner, because the ICF/MR receiving reimbursement under this section is not able, as determined by the commissioner, to provide the intervention and protection of the recipient and others living with the recipient that is necessary to prevent the recipient from requiring placement in a more restrictive institutional setting.

(c) Residential crisis services providers must maintain a license from the commissioner for the residence when providing crisis services for short-term crisis intervention, and must not be located in a private residence.

(d) Payment rates shall be established consistent with county negotiated crisis intervention services.

(e) Payment for residential crisis services is limited to 21 days, unless an additional period is authorized by the commissioner or part of an approved regional plan.

(f) Payment for crisis services shall be made only for services provided while the ICF/MR receiving reimbursement under this section:

~~(1) has a shared services agreement with the crisis services provider in effect under section 246.57; and~~

~~(2)~~ has executed a cooperative agreement with the crisis services provider to implement the intervention plan and revisions to the individual service plan as necessary to prevent or minimize the likelihood of future crisis situations, to maintain the recipient in the present community setting, and to prevent the recipient from requiring a more restrictive institutional setting.

(g) Payment to the ICF/MR receiving reimbursement under this section shall be made for up to 18 therapeutic leave days during which the recipient is receiving residential crisis services, if the ICF/MR is otherwise eligible to receive payment for a therapeutic leave day under Minnesota Rules, part 9505.0415. Payment under this paragraph shall be terminated if the commissioner determines that the ICF/MR is not meeting the terms of the ~~shared~~ cooperative service agreement under paragraph (f) or that the recipient will not return to the ICF/MR.

Sec. 13. Minnesota Statutes 1999 Supplement, section 256B.5011, subdivision 2, is amended to read:

Subd. 2. **CONTRACT PROVISIONS.** (a) The service contract with each intermediate care facility must include provisions for:

(1) modifying payments when significant changes occur in the needs of the consumers;

(2) the establishment and use of ~~continuous~~ a quality improvement ~~processes using the results attained through service quality monitoring~~ plan. Using criteria and options for performance measures developed by the commissioner, each intermediate care facility must identify a minimum of one performance measure on which to focus its efforts for quality improvement during the contract period;

(3) appropriate and necessary statistical information required by the commissioner;

(4) annual aggregate facility financial information; and

(5) additional requirements for intermediate care facilities not meeting the standards set forth in the service contract.

~~(b) The commissioner shall recommend to the legislature by January 15, 2000, whether the contract should include service quality monitoring that may utilize performance indicators that measure consumer and program outcomes. Performance measurement shall not increase or duplicate regulatory requirements.~~

New language is indicated by underline, deletions by ~~strikeout.~~

(b) The commissioner of human services and the commissioner of health, in consultation with representatives from counties, advocacy organizations, and the provider community, shall review the consolidated standards under chapter 245B and the supervised living facility rule under Minnesota Rules, chapter 4665, to determine what provisions in Minnesota Rules, chapter 4665, may be waived by the commissioner of health for intermediate care facilities in order to enable facilities to implement the performance measures in their contract and provide quality services to residents without a duplication of or increase in regulatory requirements.

Sec. 14. Minnesota Statutes 1999 Supplement, section 256B.5013, subdivision 1, is amended to read:

Subdivision 1. **VARIABLE RATE ADJUSTMENTS.** For rate years beginning on or after October 1, 2000, when there is a documented increase in the resource needs of a current ICF/MR recipient or recipients, or a person is admitted to a facility who requires additional resources, the county of financial responsibility may ~~approve~~ recommend approval of ~~an enhanced~~ a variable rate ~~for one or more persons in the~~ to enable the facility to meet the needs based on the recipient's screening. Resource needs directly attributable to an individual that may be considered under the variable rate adjustment include increased direct staff hours and other specialized services, equipment, and human resources. The guidelines in paragraphs (a) to (d) apply for the payment rate adjustments under this section.

(a) All persons must be screened according to section 256B.092, subdivisions 7 and 8, prior to implementation of the new payment system, and annually thereafter, and when a variable rate is being requested due to changes in the needs of the recipient. Screening data shall be analyzed to develop broad profiles of the functional characteristics of recipients. ~~Three components shall~~ Criteria to be used to ~~distinguish recipients based on the following broad~~ develop these profiles shall include, but not be limited to:

(1) the functional ability of a recipient to care for and maintain ~~one's~~ the recipient's own basic needs;

(2) the intensity of any aggressive or destructive behavior; ~~and~~

(3) any history of obstructive behavior in combination with a diagnosis of psychosis or neurosis.;

(4) a need for resources due to a change in resident day program participation because the resident: (i) has reached the age of 65 or has a change in health condition that makes it difficult for the person to participate in day training and habilitation services over an extended period of time because it is medically contraindicated; and (ii) has expressed a desire for change through the developmental disabilities screening process under section 256B.092; and

(5) a need for additional resources for intensive short-term training which is necessary prior to a recipient's discharge to a less restrictive, more integrated setting.

The ~~profile groups~~ recipients' screenings shall be used to link resource needs to funding. The resource profile shall determine the level of funding ~~that may be authorized by the county. The county of financial responsibility may approve a rate adjustment for an individual. The commissioner shall recommend to the legislature by January 15, 2000, a methodology using the profile groups to determine variable rates.~~ The variable rate must be applied to expenses related to increased direct staff hours and other specialized services, equipment, and human resources. ~~This variable rate component plus the facility's current operating payment rate equals the individual's total operating payment rate.~~

(b) A recipient must be screened by the county of financial responsibility using the developmental disabilities screening document completed immediately prior to approval of a variable rate by the county. A comparison of the updated screening and the previous screening must demonstrate an increase in resource needs.

(c) Rate adjustments projected to exceed the authorized funding level associated with the person's profile must be submitted to the commissioner.

(d) ~~The new rate approved through this process shall not be averaged across all persons living at a facility but shall be an individual rate.~~ The county of financial responsibility must indicate the projected length of time that the additional funding may be needed ~~by~~ for the individual. The need to continue an individual variable rate must be reviewed at the end of the anticipated duration of need but at least annually through the completion of the developmental disabilities screening document.

Sec. 15. Minnesota Statutes 1999 Supplement, section 256B.5013, is amended by adding a subdivision to read:

Subd. 5. **REQUIRED DATA; PAYMENT ADJUSTMENTS.** Facilities shall maintain and submit monthly bed use data in the form of resident days and variable rate information. When a variable rate is reported by a facility, monthly bed use data shall be used to track the amount and time span of the rate adjustment. The total payments made to a facility may be adjusted based on concurrent changes in the needs of recipients that are covered by a variable rate adjustment. Any adjustment for multiple resident changes shall not result in a decrease to the facility base rate.

Sec. 16. Minnesota Statutes 1999 Supplement, section 256B.5013, is amended by adding a subdivision to read:

Subd. 6. **COMMISSIONER REVIEW.** During the initial contracting period, the commissioner shall review the process of variable rate adjustments to determine if the variable rate process is being effectively implemented and whether the variable rate process minimizes unnecessary detailed recordkeeping and meets recipient needs.

Sec. 17. Minnesota Statutes 1999 Supplement, section 256B.77, subdivision 8, is amended to read:

Subd. 8. **RESPONSIBILITIES OF THE COUNTY ADMINISTRATIVE ENTITY.** (a) The county administrative entity shall meet the requirements of this subdivision, unless the county authority or the commissioner, with written approval of

the county authority, enters into a service delivery contract with a service delivery organization for any or all of the requirements contained in this subdivision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(p) The county administrative entity shall contract with schools and other agencies as appropriate to provide otherwise covered medically necessary medical assistance services as described in an enrollee's individual family support plan, as described in sections 125A.26 to 125A.48, or individual education plan, as described in chapter 125A.

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

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

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

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

(u) Prepaid health plans serving counties with a nonprofit community clinic or community health services agency must contract with the clinic or agency to provide services to clients who choose to receive services from the clinic or agency, if the clinic or agency agrees to payment rates that are competitive with rates paid to other health plan providers for the same or similar services.

For purposes of this paragraph, "nonprofit community clinic" includes, but is not limited to, a community mental health center as defined in sections 245.62 and 256B.0625, subdivision 5.

Sec. 18. **EFFECTIVE DATE.**

Section 6, amending section 256B.0625, subdivision 19a, is effective the day following final enactment.

Presented to the governor May 11, 2000

Signed by the governor May 15, 2000, 10:27 a.m.

CHAPTER 475—H.F.No. 3229

An act relating to Hennepin county; providing for payment of county obligations by electronic transfer or credit card; amending Minnesota Statutes 1998, section 383B.116, subdivision 2, and by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 383B.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 1998, section 383B.116, subdivision 2, is amended to read:

Subd. 2. **PAYMENT ~~BY WARRANT~~ METHODS.** Payments of claims and obligations of the county ~~shall~~ may be made by warrant, check, or all forms of electronic or wire funds transfer. Section 471.38 does not apply to any claim for which payment is made by electronic or wire funds transfer. Where the county is authorized by law to make investments, ~~persons designated by the board may, in accordance with rules and procedures established by the administrator,~~ the county may make electronic