CHAPTER 9505
DEPARTMENT OF HUMAN SERVICES
HEALTH CARE PROGRAMS

9505.0115 REDETERMINATION OF ELIGIBILITY.

[For text of subps 1 and 2, see M.R.]

Subp. 3. **Periodic redetermination.** The local agency shall perform periodic redeterminations before the end of the eligibility periods defined in part 9505.0110, subpart 2, items A and B, so that eligibility is not interrupted because of agency delay of redetermination. The local agency shall review semiannually those cases where the person's assets are within $300 of the asset limitations in parts 9505.0059 and 9505.0060.

[For text of subps 4 and 5, see M.R.]

Statutory Authority: *MS s 256B.04*

History: *14 SR 2632*

9505.0175 DEFINITIONS.

[For text of subps 1 to 26, see M.R.]

Subp. 27. **Mental health practitioner.** "Mental health practitioner" means a person who is qualified in at least one of the ways specified in Minnesota Statutes, section 245.462, subdivision 17.

Subp. 28. **Mental health professional.** "Mental health professional" means a person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

A. in psychiatric nursing, a registered nurse licensed under Minnesota Statutes, sections 148.171 to 148.285 and certified as a clinical specialist in psychiatric or mental health nursing by the American Nurses Association;

B. in clinical social work, a person licensed as an independent clinical social worker under Minnesota Statutes, section 148B.21, subdivision 6;

C. in psychology, a psychologist licensed under Minnesota Statutes, sec-

tions 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental illness; or

D. in psychiatry, a physician licensed under Minnesota Statutes, chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry.

[For text of subps 29 to 50, see M.R.]

Statutory Authority: *MS s 256B.04; 256B.0625*

History: *14 SR 8*

9505.0260 COMMUNITY MENTAL HEALTH CENTER SERVICES.

Subpart 1. **Definitions.** For purposes of this part, the following terms have the meanings given them.

A. "Community mental health center service" means services by a community mental health center that provides mental health services specified in part 9505.0323, subpart 2, and physician services under part 9505.0345, including the determination of a need for prescribed drugs and the evaluation of prescribed drugs.

B. Notwithstanding the definition of "supervision" in part 9505.0175, subpart 46, "supervision" means "clinical supervision" as defined in part 9505.0323, subpart 1, item D.

C. For purposes of this part, "mental health professional" means a "mental health professional" as defined in part 9505.0175, subpart 28 and a person licensed in marriage and family therapy under Minnesota Statutes, sections 148B.29 to 148B.39 and employed by a provider of community mental health center services.

Subp. 2. **Eligible providers of community mental health center services.** To be eligible to enroll in the medical assistance program as a provider of community mental health center services, a provider must:

A. be established as specified in Minnesota Statutes, section 245.62;

B. obtain the commissioner's approval according to Minnesota Statutes, section 245.69, subdivision 2;

C. be a private, nonprofit corporation or a public agency;

D. have a board of directors established under Minnesota Statutes, section 245.66;

E. be operated by or under contract with a local agency to provide community mental health services;

F. comply with parts 9520.0750 to 9520.0870 and other parts of chapter 9520 applicable to community mental health centers;

G. provide mental health services as specified in Minnesota Statutes, section 245.62, subdivision 4;

H. provide mental health services specified in Minnesota Statutes, sections 245.461 to 245.486;

I. have a sliding fee schedule; and

J. if providing services to persons with alcohol and other drug problems, be licensed to provide outpatient treatment under parts 9530.5000 to 9530.6500.

Subp. 3. **Payment limitation; community mental health center services.** Medical assistance payment limitations applicable to community mental health center services include the payment limitations in part 9505.0323.

Subp. 4. **Payment limitation; supervision of service before September 1, 1990.** To be eligible for medical assistance payment, a community mental health center service that is provided to a recipient before September 1, 1990, must be under the supervision of a psychiatrist, licensed consulting psychologist, or licensed psychologist who is a provider.

Subp. 5. **Excluded services.** The services listed in part 9505.0323, subpart 27, are not eligible for medical assistance payment as community mental health services.

Statutory Authority: *MS s 256B.04; 256B.0625*

History: *14 SR 8*

9505.0323 MENTAL HEALTH SERVICES.

Subpart 1. **Definitions.** For this part, the following terms have the meanings given them.

A. "Biofeedback" means a service designed to assist a client to regulate a bodily function controlled by the autonomic nervous system, such as heartbeat or blood pressure, by using an instrument to monitor the function and signal the changes in the function.

B. "Child" means a person under 18 years of age.

C. "Client" means a recipient who is determined to be mentally ill as specified in subpart 2.

D. "Clinical supervision" means the process of control and direction of a client's mental health services by which a mental health professional who is a provider accepts full professional responsibility for the supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the work of the supervisee. The process must meet the conditions in subitems (1) to (3).

(1) The provider must be present and available on the premises more than 50 percent of the time in a five working day period during which the supervisee is providing a mental health service.

(2) The diagnosis and the client's individual treatment plan or a change in the diagnosis or individual treatment plan must be made by or reviewed, approved, and signed by the provider.

(3) Every 30 days the supervisor must review and sign the record of the client's care for all activities in the preceding 30-day period.

E. "Day treatment" or "day treatment program" means a structured program of treatment and care provided to persons in:

(1) an outpatient hospital accredited by the Joint Commission on the Accreditation of Hospitals and licensed under Minnesota Statutes, sections 144.50 to 144.55;

(2) a community mental health center under part 9505.0260; or

(3) an entity that is under contract with the county to operate a program that meets the requirements of Minnesota Statutes, section 245.471, subdivision 3, and parts 9505.0170 to 9505.0475.

Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided by a multidisciplinary staff. The services are aimed at stabilizing the client's mental health status, providing mental health services, and developing and improving the client's independent living and socialization skills. The goal of day treatment is to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. Day treatment services are not a part of inpatient or residential treatment services. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services.

F. "Diagnostic assessment" has the meaning given in part 9505.0477, subpart 10.

G. "Explanation of findings" means analysis and explanation of a diagnostic assessment, psychological testing, client's treatment program, or other accumulated data and recommendations to the client's family, primary caregiver, or other responsible persons. Examples of responsible persons are a qualified

mental retardation professional; a case manager; providers; a child protection worker; a vulnerable adult worker; the recipient's guardian, if any; and representatives of a local education education agency, school, or community corrections agency that has a responsibility to provide services for the recipient.

H. "Family psychotherapy" means psychotherapy as specified in subpart 13 that is designed for the client and one or more persons who are related to the client by blood, marriage, or adoption, or who are the client's foster parents, the client's primary caregiver, or significant other and whose participation is necessary to accomplish the client's treatment goals. For purposes of this item, "persons whose participation is necessary to accomplish the client's treatment goals" does not include shift or facility staff members at the client's residence.

I. "Group psychotherapy" means psychotherapy conducted by a mental health professional for more than three but not more than eight persons or psychotherapy co-conducted by two mental health professionals for at least nine but not more than 12 persons who because of the nature of their emotional, behavioral, or social dysfunctions can derive mutual benefit from interaction in a group setting.

J. "Hour" means a 60-minute session of mental health service other than a diagnostic assessment. At least 45 minutes of the period must be spent in face-to-face contact with the client. The other 15 minutes may be spent in client-related activities. Examples of client-related activities are scheduling, maintaining clinical records, consulting with others about the client's mental health status, preparing reports, receiving the clinical supervision directly related to the client's psychotherapy session, and revising the client's individual treatment plan. If the period of service is longer or shorter than one hour, up to one-fourth of the time may be spent in client-related activities.

K. "Hypnotherapy" means psychotherapeutic treatment through hypnosis induced by a mental health professional trained in hypnotherapy.

L. "Individual psychotherapy" means psychotherapy designed for one client. For purposes of this part, hypnotherapy and biofeedback are individual psychotherapy.

M. "Individual treatment plan" has the meaning given it in part 9505.0477, subpart 14.

N. "Mental health services" means the services defined in items A, E, F, G, H, I, K, L, Q, S, T, U, and V and subpart 30.

O. "Mental illness" has the meaning given it in part 9505.0477, subpart 20.

P. "Neurological examination" means an examination of a person's nervous system by or under the supervision of a physician skilled in the diagnosis and treatment of disorders of the nervous system.

Q. "Partial hospitalization" or "partial hospitalization program" means a time-limited, structured program of psychotherapy and other therapeutic services provided in an outpatient hospital licensed under Minnesota Statutes, sections 144.50 to 144.55 and accredited by the Joint Committee on Accreditation of Hospitals. Partial hospitalization is an appropriate alternative or adjunct to inpatient hospitalization for a client who is experiencing an acute episode of mental illness that meets the criteria for an inpatient hospital admission as specified in part 9505.0540, subpart 1, and who has the family and community resources necessary and appropriate to support the client's residence in the community. Partial hospitalization consists of multiple and intensive therapeutic services provided by a multidisciplinary staff to treat the client's mental illness. The goal of partial hospitalization is to resolve or stabilize an acute episode of mental illness. Examples of services provided in partial hospitalization are individual, group, and family psychotherapy services.

R. Notwithstanding the definition in part 9505.0477, subpart 23, "pri-

mary caregiver" means a person who has primary responsibility for providing the recipient with food, clothing, shelter, direction, guidance, and nurturance. A primary caregiver is someone other than the recipient's parent or a shift or facility staff member in a facility or institution where the recipient is residing or receiving a health service. An example of a primary caregiver is a recipient's relative who is not the recipient's parent and with whom the recipient lives.

S. "Psychological testing" means the use of tests or other psychometric instruments to determine the status of the recipient's mental, intellectual, and emotional functioning. A face-to-face interview sufficient to validate the psychological test is a required component of psychological testing.

T. "Psychotherapy" means a health service for the face-to-face treatment of a client or clients with mental illness through the psychological, psychiatric, or interpersonal method most appropriate to the needs of the client and in conformity with prevailing community standards of mental health practice. The treatment is a planned structured program or other intervention based on a diagnosis of mental illness resulting from a diagnostic assessment and is directed to accomplish measurable goals and objectives specified in the client's individual treatment plan. Individual, family, and group psychotherapy are the types of psychotherapy. Examples of psychotherapy goals and objectives are relieving subjective distress, alleviating specific existing symptoms, modifying specific patterns of disturbed behavior, stabilizing the level of functioning attainable by the client, and enhancing the ability of the client to adapt to and cope with specific internal and external stressors.

U. "Psychotherapy session" means a planned and structured face-to-face treatment episode between the vendor or provider of psychotherapy and one or more individuals. A psychotherapy session may consist of individual psychotherapy, family psychotherapy, or group psychotherapy.

V. "Multiple family group psychotherapy" means psychotherapy as specified in subpart 28.

Subp. 2. **Determination of mental illness.** Except as provided in subpart 3, a diagnostic assessment that results in a diagnosis of mental illness is the criterion used to determine a recipient's eligibility for mental health services under this part.

Subp. 3. **Payment limitation; recipient who is mentally ill.** Medical assistance payment is available for a diagnostic assessment, an explanation of findings, psychological testing, and one psychotherapy session before completion of the diagnostic assessment if the person is a recipient and the provider complies with the requirements of this part. Other mental health services to a recipient are eligible for medical assistance payment only if the recipient has a mental illness as determined through a diagnostic assessment.

Subp. 4. **Eligibility for payment; diagnostic assessment.** To be eligible for medical assistance payment, a diagnostic assessment carried out before September 1, 1990, must be conducted by a provider who is a psychiatrist, a licensed consulting psychologist, or a licensed psychologist, or conducted by a vendor who is a mental health professional, is not a provider, and is under the clinical supervision of a provider who is a psychiatrist, a physician who is not a psychiatrist, or licensed consulting psychologist. The diagnosis resulting from the assessment must be made by, or reviewed and approved by, the provider. A diagnostic assessment carried out on or after September 1, 1990, must be conducted by a provider who is a mental health professional. Additionally, to be eligible for medical assistance payment, a diagnostic assessment must comply with the requirements in items A to L.

A. A provider may receive medical assistance reimbursement for only one diagnostic assessment per calendar year per recipient unless:

(1) the recipient's mental health status has changed markedly since the recipient's most recent diagnostic assessment by the same provider; or

(2) the provider conducting the diagnostic assessment who has referred the recipient to a psychiatrist for a psychiatric consultation needs to revise the recipient's diagnostic assessment as a result of the report of the psychiatric consultation. In the event of the recipient's referral to a psychiatrist, the provider referring the recipient shall document the reason for the referral in the recipient's record.

B. Medical assistance will not pay for more than four diagnostic assessments per recipient per calendar year.

C. Except as set forth in subparts 5 and 6, medical assistance payment for a diagnostic assessment is limited to two hours per assessment.

D. A recipient may choose another provider of a diagnostic assessment but the limit in item B shall apply.

E. The limits in this subpart apply whether all components of the diagnostic assessment are carried out by one mental health professional, by more than one mental health professional, or in a multiple provider setting. Examples of a multiple provider setting are outpatient hospitals, group practices, and community mental health centers.

F. The activities necessary to complete a recipient's diagnostic assessment may be spread out over more than one day but the billing for a diagnostic assessment must be dated as of the date the diagnostic assessment is completed.

G. A diagnostic assessment carried out by a mental health professional in a multiple provider setting must be available to other mental health professionals, or other providers in the same setting who need the diagnostic assessment to provide mental health services to the recipient. Additional diagnostic assessments of the recipient in the same multiple provider setting are subject to the limit specified in item A.

H. Medical assistance does not pay for a recipient's diagnostic assessment performed on a day during which a recipient participates in a psychotherapy session unless the psychotherapy session is necessary because of an emergency or unless the psychotherapy session occurs as specified in subpart 3.

I. The mental health professional conducting the diagnostic assessment must:

(1) address the components in subpart 1, item F;

(2) conduct a face-to-face interview with the recipient;

(3) conduct a mental status examination which describes the recipient's appearance, general behavior, motor activity, speech, alertness, mood, cognitive functioning, and attitude toward his or her symptoms;

(4) review pertinent records;

(5) consider the recipient's need for referral for psychological testing, psychiatric consultation, a neurological examination, a physical examination, a determination of the need for prescribed drugs, the evaluation of the effectiveness of prescribed drugs, and a chemical dependency assessment as specified in part 9530.6615;

(6) refer the recipient for medically necessary services that are outside the scope of practice of the mental health professional;

(7) if clinically appropriate and if authorized as specified in subpart 19 or 20, contact the recipient's family or primary caregiver or document the reason the contact was not made; and

(8) record the results of the diagnostic assessment in the recipient's record.

J. Medical assistance will only pay for a neurological examination, psychiatric consultation, physical examination, determination of the need for prescribed drugs, evaluation of the effectiveness of prescribed drugs, and psychological testing carried out in conjunction with a diagnostic assessment if

they are billed as separate procedures, distinct from a diagnostic assessment under medical assistance.

K. If the mental health professional who conducts the diagnostic assessment is not the mental health professional who referred the recipient for the diagnostic assessment or the mental health professional providing psychotherapy, the mental health professional conducting the diagnostic assessment shall request the recipient to authorize release of the information of the diagnostic assessment to the mental health professional who referred the recipient for the diagnostic assessment and the mental health professional who provides the psychotherapy. The authorization must meet requirements in subpart 19 or 20. The mental health professional conducting the diagnostic assessment shall tell the recipient that any mental health professional who provides the recipient's mental health services will need access to the diagnostic assessment to develop an individual treatment plan related to the services recommended in the diagnostic assessment and to receive medical assistance payment for the recipient's mental health services.

L. The mental health professional conducting the diagnostic assessment must complete the diagnostic assessment no later than the second meeting between the recipient and the mental health professional providing the recipient's psychotherapy.

Subp. 5. **Extension of time available to complete a recipient's diagnostic assessment.** The two-hour time limit in subpart 4, item C, for completing the diagnostic assessment does not apply if the mental health professional conducting the diagnostic assessment documents in the recipient's record that the recipient has a condition specified in item A and a circumstance specified in item B, C, or D, is present. In this event, medical assistance will pay for the recipient's diagnostic assessment of up to eight hours in length and the mental health professional conducting the diagnostic assessment must develop the recipient's individual treatment plan. The mental health professional conducting the diagnostic assessment must document in the recipient's record the circumstances requiring the extended time. For purposes of this subpart, "initial diagnostic assessment" refers to the first time that a recipient receives a diagnostic assessment of a set of symptoms indicating a possible mental illness.

A. The recipient has a diagnosis of mental illness and is:

(1) A person with mental retardation as defined in part 9525.0015, subpart 20, or a related condition as defined in Minnesota Statutes, section 252.27, subdivision 1.

(2) A hearing impaired person as defined in Minnesota Statutes, section 256C.23, subdivision 2.

(3) A person with a speech and language impairment. For purposes of this subitem, "speech and language impairment" means a speech behavior that deviates significantly from the normal or standard speech pattern and attracts attention to the process of speech or interferes with oral communication or adversely affects either the speaker or the listener. An impairment may affect:

(a) the way a sound is formed by persons with cleft palates, cerebral palsy, mental retardation, or related conditions;

(b) the time relationships between sounds, as in stuttering;

(c) the voice, as in a laryngectomy; and

(d) the ease in comprehending the speech of others or in orally projecting one's own ideas, as in cases of aphasia caused by strokes and other cerebral trauma.

(4) A child under 18 years of age who exhibits severe oppositional behavior during the diagnostic assessment, who has not had a previous diagnostic assessment, and whose case record documents the severe oppositional behavior.

(5) A child under 18 years of age whose mental illness results in

behavior that unreasonably interferes with the mental health professional's ability to conduct the diagnostic assessment and whose case record documents the behavior.

(6) A person who meets the criteria in subpart 7, item B.

B. An extension of the time for an initial diagnostic assessment is necessary to develop the recipient's individual treatment plan.

C. An extension of the time for an initial diagnostic assessment has been authorized by the case manager according to parts 9525.0015 to 9525.0165.

D. An extension of the time to carry out the activities for a substantial revision of the client's individual treatment plan is necessary because of significant changes in the client's behavior or living arrangement.

Subp. 6. **Prior authorization of additional time to complete a diagnostic assessment.** A mental health professional must obtain prior authorization to exceed the time limits placed on a recipient's diagnostic assessment in subparts 4 and 5. Prior authorization of up to eight hours of diagnostic assessment in a calendar year in addition to the time limit of eight hours available under the circumstances specified in subpart 5 shall be approved if the mental health professional documents that the recipient meets the criteria in subpart 7. The additional hours of assessment must result in an individual treatment plan that has objectives designed to develop adaptive behavior and that specifies the anticipated behavioral change and the expected schedule for achieving the anticipated behavioral change.

Additionally, the request for prior authorization of additional hours to complete the diagnostic assessment must document that the additional hours are necessary and is limited to the additional observation and interviews needed to:

A. establish the baseline measurement of the recipient's behavior;

B. determine the cause of the recipient's behavior such as the recipient's attempts to communicate with others or control his or her environment; and

C. determine the effects of the recipient's physical and social environments on the recipient's behavior.

Subp. 7. **Criteria for prior authorization of additional time to complete a diagnostic assessment.** A request for prior authorization of additional time to complete a recipient's diagnostic assessment shall be approved if the recipient meets the criteria in items A and B or the criteria in item C.

A. The recipient meets the criteria in subpart 5 for extended assessment activity.

B. The recipient has a severe behavior disorder that is manifested as:

(1) Self-injurious behavior that is a clear danger to the recipient. Examples of self-injurious behavior are ingesting inedibles; removing items of clothing; striking, biting, or scratching oneself; moving into dangerous situations that clearly threaten or endanger the recipient's life, sensory abilities, limb mobility, brain functioning, physical appearance, or major physical functions.

(2) Aggressive behavior that is a clear danger to others. Examples of aggressive behaviors are striking, scratching, or biting others; throwing objects at others; attempting inappropriate sexual activity with others; or pushing or placing others into dangerous situations that clearly threaten or endanger their life, sensory abilities, limb mobility, brain functioning, sexual integrity, physical appearance, or other major physical functions.

(3) Destructive behavior that results in extensive property damage.

C. The recipient experienced a significant change in behavior or living arrangement and the recipient meets the criteria in items A and B.

Subp. 8. **Payment rate; diagnostic assessment.** Medical assistance for a diagnostic assessment that meets the requirements in subparts 4 to 7 shall be paid according to the hourly payment rate for individual psychotherapy.

Subp. 9. **Payment limitation; length of psychotherapy session.** Medical assistance payment for a psychotherapy session is limited according to items A to D.

A. The length of an individual psychotherapy session, including hypnotherapy and biofeedback, may be either one-half hour or one hour.

B. The length of a family psychotherapy session shall be one hour or 1-1/2 hours.

C. The length of a group psychotherapy session shall be one hour, 1-1/2 hours, or two hours.

D. If the length of a psychotherapy session is less than an hour or a whole number multiple of an hour, payment will be prorated according to the lesser length of time.

Subp. 10. **Limitations on medical assistance payment for psychotherapy sessions.** There are limitations on medical assistance payment for psychotherapy sessions as specified in the list of health services published according to Minnesota Statutes, section 256B.02, subdivision 8y.

Subp. 11. **Prior authorization of psychotherapy sessions beyond the limitations.** The provider must obtain prior authorization to exceed the limits in subpart 10 unless the psychotherapy session is in response to an emergency as specified in part 9505.5015, subpart 2. In the event of an emergency, the provider must submit a request for prior authorization within five working days after the emergency psychotherapy session.

Subp. 12. **Payment limitation; total payment for group psychotherapy.** To be eligible for medical assistance payment, a group psychotherapy session conducted by one mental health professional shall not have more than eight persons, and a group psychotherapy session conducted by two mental health professionals shall have at least nine but not more than 12 persons. These limits shall apply regardless of the participants' eligibility for medical assistance. Medical assistance payment for each client who participates in a session of group psychotherapy shall be one quarter of the hourly payment rate for an hour of individual psychotherapy. However, in the case of a group pyschotherapy session conducted by two mental health professionals, medical assistance payments shall be according to the number of participants attending the session. When a client participates in a session of group psychotherapy conducted by two mental health professionals, the client's record must document that the cotherapy is medically necessary.

Subp. 13. **Payment limitation; family psychotherapy.** Medical assistance payment for family psychotherapy shall be per psychotherapy session regardless of the medical assistance eligibility status or the number of family members who participate in the family psychotherapy session. Medical assistance payment for family psychotherapy is limited to face-to-face sessions at which the client is present throughout the family psychotherapy session unless the mental health professional believes the client's absence from the family psychotherapy session is necessary to carry out the client's individual treatment plan. If the client is excluded, the mental health professional must document the reason for and the length of the time of the exclusion. Furthermore, the mental health professional must document the reason or reasons why a member of the client's family is excluded.

Subp. 14. **Payment limitation; partial hospitalization.** To be eligible for medical assistance payment, a partial hospitalization program must be reviewed by and have received a letter of approval from the department. Additionally, partial hospitalization must meet the requirements in items A to F.

A. The provider of the partial hospitalization must receive prior authorization before the client's partial hospitalization begins, except as set forth in part 9505.5015, subpart 2.

B. The service is provided to a client who is an outpatient with the diag-

nosis of mental illness and the service is provided more than 14 days after the client is discharged as an inpatient with a diagnosis of mental illness.

C. A partial hospitalization program for a client who is at least 18 years of age must provide at least six hours of services per day. Medical assistance payment for partial hospitalization is limited to no more than 16 days within a 30 calendar day period. The partial hospitalization must take place on at least four but not more than five days in any week within the 30 calendar day period.

D. A partial hospitalization program for a client who is less than 18 years of age must provide at least five hours of services per day. Medical assistance payment for partial hospitalization is limited to no more than 40 days within a period of ten consecutive weeks. The partial hospitalization must take place on at least four but not more than five days in any week within the ten consecutive week period.

E. The definition of hour in subpart 1, item J, applies to partial hospitalization.

F. Prior authorization may be requested once for up to 16 days of additional partial hospitalization in the case of a client who is at least 18 years of age or for up to 40 days of additional partial hospitalization in the case of a client who is less than 18 years of age. If the request is approved by the department, the partial hospitalization must comply with the requirements of items A, B, and E, and also with item C in the case of a client who is at least 18 years of age or with the requirements of item D in the case of a client who is less than 18 years of age.

Subp. 15. **Payment limitation; general provisions about day treatment services.** Medical assistance payment for day treatment services to a client shall be limited to 390 hours of day treatment in a calendar year unless prior authorization is obtained for additional hours within the same calendar year. To be eligible for medical assistance payment, a day treatment program must be reviewed by and have received the approval of the department. The treatment must be provided to a group of clients by a multidisciplinary staff under the clinical supervision of a mental health professional. The program must be available at least one day a week for a minimum three-hour time block. The day treatment may be longer than three hours per day but medical assistance payment is limited to three hours per day. To be eligible for medical assistance payment, the three-hour time block must include at least one hour but no more than two hours of individual or group psychotherapy. The remainder of the three-hour time block must consist of any of the following: recreation therapy, socialization therapy, and independent living skills therapy. In addition, the remainder of the three-hour time block can include recreation therapy, socialization therapy, and independent living skills therapy only if they are included in the client's individual treatment plan as necessary and appropriate. Notwithstanding the documentation of each service required under subpart 26, documentation of day treatment may be provided on a daily basis by use of a checklist of available therapies in which the client participated and on a weekly basis by a summary of the information required under subpart 26.

Subp. 16. **Payment limitation; noncovered services provided by day treatment program.** The following services are not covered by medical assistance if they are provided by a day treatment program:

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

B. A social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's mental illness.

C. Consultation with other providers or service agency staff about the care or progress of a client.

D. Prevention or education programs provided to the community.

E. Day treatment for recipients with primary diagnoses of alcohol or other drug abuse.

F. Day treatment provided in the client's home.

G. Psychotherapy for more than two hours daily.

H. Recreation therapy and teaching socialization therapy and independent living skills therapy for more than one hour daily each unless the client's individual treatment plan prescribes more than one hour daily.

I. Participation in meal preparation and eating that is not medically supervised and included in the client's individual treatment plan as necessary and appropriate.

Subp. 17. **Payment limitation; service to determine the need for or to evaluate the effectiveness of prescribed drugs.** Payment for a physician service to a client to determine a client's need for a prescribed drug or to evaluate the effectiveness of a drug prescribed in a client's individual treatment plan is limited according to part 9505.0345, subpart 5. To be covered by medical assistance, the evaluation of the effectiveness of a drug prescribed in a client's individual treatment plan must be carried out face-to-face by a physician or by a mental health professional who is qualified in psychiatric nursing as specified in Minnesota Statutes, section 245.462, subdivision 18, clause (1), or a registered nurse who is qualified as a mental health practitioner as specified in Minnesota Statutes, section 245.462, subdivision 17. A nurse who evaluates a client's prescribed drugs must be employed by or under contract to a provider and must be under the supervision of a physician who is on site at least 50 percent of the time the service is being provided. For purposes of this subpart, "evaluation of the effectiveness of a drug prescribed in a client's individual treatment plan" or "evaluation of a client's prescribed drugs" means adjusting a client's medication to mitigate the client's symptoms, alleviate the client's distress, and determine the impact of the client's medication on the client's functioning at work and in daily living.

Subp. 18. **Payment limitation; explanation of findings.** Explanation of findings is a covered service under parts 9505.0170 to 9505.0475. Medical assistance payment for explanations of findings is limited to four hours per recipient per calendar year. Unless the recipient's diagnostic assessment meets the requirements of subparts 5 to 7, medical assistance payment will not pay for more than a one-hour explanation of findings after the mental health professional completes the recipient's diagnostic assessment. The mental health professional providing the explanation of findings may use the time available under this subpart for an explanation of findings in units of one-half hour or one hour but the total must not exceed the amount specified in this subpart. To be eligible for medical assistance payment, the mental health professional providing the explanation of findings must have obtained the authorization of the recipient or the recipient's representative to release the information as required in subpart 19 or 20. If the recipient's diagnostic assessment qualifies for an extension of or additional time as provided in subparts 5 to 7, the mental health professional providing the explanation of findings may allocate the calendar year total of four hours in any manner necessary to explain the findings. Medical assistance only pays for the actual time spent or four hours, whichever amount of time is less.

Subp. 19. **Authorization to access or release information about a recipient.** To obtain medical assistance payment, in the case of a client who is an adult, a mental health professional providing a mental health service must ask a recipient or the recipient's legal representative to sign forms needed to authorize access or release of information about a recipient's health status. The form must contain the information in items A to H and room for the person's signature. If the recipi-

ent or the recipient's legal representative refuses to sign the authorization, the mental health professional must not access or release the information and must document the refusal to sign and the reason for the refusal in the recipient's record. The period of authorization must not exceed one year. The authorization form must state:

A. the person's name;

B. the date;

C. the specific nature of the information authorized to be accessed or released;

D. who is authorized to give information;

E. to whom the information is to be given;

F. the information's use;

G. the date of expiration of the authorization; and

H. that the recipient may revoke consent at any time.

For purposes of this subpart and subpart 20, "legal representative" means a guardian or conservator authorized by the court to make decisions about services for a person, or other individual authorized to consent to services for the person.

Subp. 20. **Authorization to provide service or to access or release information about a recipient who is a child.** To obtain medical assistance payment, in the case of a client who is a child, a mental health professional who wants to provide a mental health service to a child or who is required to access or release information related to the child's mental health status and services must obtain the authorization of the child's parent or legal representative unless a condition specified in item A, B, or C, applies.

The authorization of service must state the child's name, the service or services authorized, the person or persons authorized to provide the service, the amount, frequency, scope, and duration of each service, the goals of the service, the date of the authorization, and the relationship between the person giving the authorization and the child. The authorization to access or release information must comply with subpart 19, items A to H. An authorization of services under this subpart must not exceed one year. Authorization by the child's parent or legal representative is not required if:

A. The parent or legal representative is hindering or impeding the child's access to mental health services.

B. The child:

(1) has been married or has borne a child as specified in Minnesota Statutes, section 144.342;

(2) is living separate and apart from the child's parents or legal guardian and is managing the child's financial affairs as specified in Minnesota Statutes, section 144.341;

(3) is at least 16 but under 18 years old and has consented to treatment as specified in Minnesota Statutes, section 253B.03, subdivision 6; or

(4) is at least 16 but under 18 years old and for whom a county board has authorized independent living pursuant to a court order as specified in Minnesota Statutes, section 260.191, subdivision 1, paragraph (a), clause (4).

C. A petition has been filed under Minnesota Statutes, chapter 260, or a court order has been issued under Minnesota Statutes, section 260.133 or 260.135, and a guardian ad litem has been appointed.

If item A or B applies, the mental health professional shall request the child to complete the required forms.

If item C applies, the mental health professional shall request the guardian ad litem to complete the required forms.

Subp. 21. **Payment limitation; psychological testing.** Medical assistance payment for psychological testing of a recipient in a calendar year shall not exceed eight times the medical assistance payment rate for an hour of individual psychotherapy. Psychological testing shall be reimbursed according to the psychological test used. The psychological testing must be conducted by a psychologist with competence in the area of psychological testing as stated to the board of psychology. The psychological testing must be validated in a face-to-face interview between the recipient and a licensed psychologist or licensed consulting psychologist with competence in the area of psychological testing. The report resulting from the psychological testing must be signed by the psychologist conducting the face-to-face interview, must be placed in the recipient's record, and must be released to each person authorized by the recipient. The required components of psychological testing, which include face-to-face interview, interpretation, scoring of the psychological tests, and the required report of testing, are not eligible for a separate charge to medical assistance. Payment for these required components is included in the amount paid for the psychological testing. The administration, scoring, and interpretation of the psychological tests may be carried out, under the clinical supervision of a licensed psychologist or licensed consulting psychologist, by a psychometrist or psychological assistant or as part of a computer-assisted psychological testing program.

Subp. 22. **Eligible vendors of mental health service before September 1, 1990.** Before September 1, 1990, a mental health service performed by a vendor who is an employee of a provider must meet the conditions in item A or B to be eligible for medical assistance payment.

A. A mental health professional must be, or be under the clinical supervision of, a psychiatrist, a physician who is not a psychiatrist, a licensed psychologist, or a licensed consulting psychologist. The supervisor must be a provider.

B. A mental health practitioner must be under the clinical supervision of a psychiatrist, a licensed psychologist, or a licensed consulting psychologist. The supervisor must be a provider.

Subp. 23. **Medical assistance payment for mental health service beginning September 1, 1990.** Beginning September 1, 1990, a mental health service provided by a mental health professional is a covered service. Beginning September 1, 1990, a mental health service other than day treatment that is provided by a mental health practitioner is not eligible for medical assistance payment. To be eligible for medical assistance payment, day treatment provided by a mental health practitioner or any other person who is not a mental health professional who is a provider must be under the clinical supervision of a mental health professional who is a provider.

Subp. 24. **Payment limitation; person completing requirements for licensure or board certification as mental health professional.** Medical assistance payment is available for mental health services provided by a person who has completed all requirements for licensure or board certification as a mental health professional except the requirements for supervised experience in the delivery of mental health services in the treatment of mental illness under this subpart. Mental health services may also be provided by a person who is a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional. The person providing the service must be under the clinical supervision of a fully qualified mental health professional who is a provider. The person must be employed by or placed in an outpatient hospital, a physician-directed clinic, a community mental health center, or a facility approved for insurance reimbursement according to parts 9520.0750 to 9520.0870. Medical assistance for services performed according to this subpart shall be paid at one-half the medical assistance payment rate for the same service provided by a fully qualified person.

Subp. 25. **Individual treatment plan.** Except as provided in subpart 3, medical

assistance payment is available only for services in accordance with the client's individual treatment plan. The individual treatment plan must meet the standards of this subpart. A client's individual treatment plan must be based on the information and outcome of the client's diagnostic assessment conducted as specified in subpart 4. Except as provided in subparts 5 and 6, the individual treatment plan must be developed by the mental health professional who provides the client's psychotherapy, or the mental health practitioner who is under the clinical supervision of a mental health professional who is a provider and must be developed no later than the end of the first psychotherapy session after the completion of the client's diagnostic assessment. The mental health professional or the mental health practitioner must involve the client in the development, review, and revision of a client's individual treatment plan. The plan must be reviewed at least once every 90 days, and if necessary revised. However, revisions of the initial individual treatment plan do not require a new diagnostic assessment unless the client's mental health status has changed markedly as provided in subpart 4, item A. The mental health professional shall request the client, or in the case of a child whose circumstances do not fall within subpart 21, the child's parent, primary caregiver, or other person authorized by statute to consent to mental health services for the child, to sign the client's individual treatment plan and revision of the plan unless the request is not appropriate to the client's mental health status. If the client refuses to sign the plan or a revision of the plan, the mental health professional or mental health practitioner shall note on the plan the client's refusal to sign the plan and the client's reason or reasons for the refusal. If the client's mental health status contraindicates the request, the mental health professional or mental health practitioner shall note on the plan the reason the client was not requested to sign the plan.

Subp. 26. **Documentation of the provision of mental health service.** To obtain medical assistance payment, a mental health professional or a mental health practitioner providing a mental health service must document in the client's record (1) each occurrence of the client's service including the date, type, length, and scope of the mental health service; (2) the name of the person who gave the service; (3) contact made with other persons interested in the recipient such as representatives of the courts, corrections systems, or schools including the name and date of the contact; (4) any contact made with the client's other mental health providers, case manager, family members, primary caregiver, legal representative, or, if applicable, the reason the client's family members, primary caregiver, or legal representative was not contacted; and (5) as appropriate, required clinical supervision. The documentation must be completed promptly after the provision of the service.

Subp. 27. **Excluded services.** The mental health services in items A to S are not eligible for medical assistance payment:

A. a mental health service that is not medically necessary;

B. a mental health service exceeding the limitations in subparts 6, 11, 14, and 15, that has not received prior authorization;

C. a mental health service other than a diagnostic assessment, psychological testing, explanation of findings, or one hour of psychotherapy before completion of the diagnostic assessment to a recipient who has not been determined to have a mental illness;

D. a diagnostic assessment made before September 1, 1990, that requires the clinical supervision of a provider, and the mental health service or services provided in response to the diagnosis made in the diagnostic assessment, if the clinical supervision was not provided;

E. a mental health service other than a diagnostic assessment, psychological testing, explanation of findings, or one hour of psychotherapy before completion of the diagnostic assessment if the service is not recommended by a mental health professional and is not part of an individual treatment plan;

F. a neurological examination carried out by a person other than a psychiatrist or psychologist with a competency in the area of neuropsychological evaluation listed with the board of psychology as in part 7200.4600, subpart 1;

G. a mental health service provided to a resident of a long-term care facility other than an intermediate care facility for the mentally retarded without the written order of the recipient's attending physician;

H. a service provided to a resident of an intermediate care facility for the mentally retarded if the service is not specified on the resident's individual service plan as set forth in part 9525.0075;

I. an evaluation of a prescribed drug by a person other than a physician or a person supervised by a physician and qualified in psychiatric nursing or as a registered nurse;

J. a service ordered by a court that is solely for legal purposes and not related to the recipient's diagnosis or treatment for mental illness;

K. services dealing with external, social, or environmental factors that do not directly address the recipient's physical or mental health;

L. a service that is only for a vocational purpose or an educational purpose that is not health related;

M. staff training that is not related to a client's individual treatment plan or plan of care;

N. child and adult protection services provided directly or indirectly by a governmental entity;

O. mental health services other than psychological testing of a recipient who is an inpatient for the purposes of psychiatric treatment;

P. psychological testing, diagnostic assessment, explanation of findings, and psychotherapy if the services are provided by a school or a local education agency unless the school or local education agency is a provider and the services are medically necessary and prescribed in a child's individual education plan;

Q. psychological testing, diagnostic assessment, explanation of findings, and psychotherapy if the services are provided by an entity whose purpose is not health service related such as the Division of Vocational Rehabilitation of the Department of Jobs and Training;

R. fundraising activities; and

S. community planning.

Subp. 28. **Multiple family group psychotherapy.** A multiple family group psychotherapy session is eligible for medical assistance payment if the psychotherapy session is designed for at least three but not more than five families. Medical assistance payment for a multiple family group shall be limited to one session of up to two hours per week for no more than ten weeks.

Subp. 29. **Required participation of psychiatrist in treatment of person with serious and persistent mental illness.** A psychiatrist must participate in the diagnostic assessment, formulation of an individual treatment plan, and monitoring of the clinical progress of a client having a mental illness that meets the definition of serious and persistent mental illness under part 9505.0477, subpart 27. The extent of the psychiatrist's participation shall be according to the individual clinical needs of the client as mutually determined by the mental health professional who is conducting the assessment and by the psychiatrist who participates. At a minimum, the psychiatrist's participation must consist of timely reviews of the activities specified in this subpart and verbal interaction between the psychiatrist and the mental health professional.

Subp. 30. **Group psychotherapy for crisis intervention.** Group psychotherapy provided to a client on a daily basis for crisis intervention is eligible for medical assistance payment as specified in items A to D.

A. The group psychotherapy must be necessary to meet the client's crisis.

B. At least three but not more than nine persons, regardless of their medical assistance eligibility, must participate in the crisis group.

C. For each crisis episode, the client may receive up to three hours per week within a period of two calendar weeks unless prior authorization is obtained for additional hours per week.

D. The number of hours of group psychotherapy provided for crisis intervention shall be included within the limit specified in subpart 10 unless prior authorization is obtained.

For the purpose of this subpart, "crisis" means any acute social, interpersonal, environmental, or intrapersonal stress that threatens the client's current level of adjustment or causes significant subjective distress.

Statutory Authority: *MS s 256B.04; 256B.0625*

History: *14 SR 8*

COMMUNITY ALTERNATIVES FOR DISABLED INDIVIDUALS PROGRAM

9505.3010 SCOPE AND EFFECT.

Subpart 1. **Scope.** Parts 9505.3010 to 9505.3140 establish standards and procedures for the community alternatives for disabled individuals program. The community alternatives for disabled individuals program allows Medicaid to pay for approved community-based services provided to eligible persons. The community-based services allow persons who would otherwise reside in a nursing home to remain at home or return to the community. Those persons must meet the requirements of part 9505.3035.

Parts 9505.3010 to 9505.3140 must be read in conjunction with section 1915(c) of the Social Security Act; Minnesota Statutes, sections 256B.04, subdivision 2; 256B.05; 256B.091, subdivisions 1 to 8; 256B.49; 256B.491; Code of Federal Regulations, title 42, sections 440.180 and 441.300 to 441.310, amended through October 1, 1987; and parts 9505.2390 to 9505.2500. Parts 9505.3010 to 9505.3140 must be read in conjunction with the requirements of the waiver obtained by the state from the United States Department of Health and Human Services.

Subp. 2. **Effect.** Parts 9505.3010 to 9505.3140 are effective only as long as the waiver from the United States Department of Health and Human Services remains in effect in Minnesota.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3015 DEFINITIONS.

Subpart 1. **Applicability.** The definitions in this part apply to parts 9505.3010 to 9505.3140.

Subp. 2. **Adaptations.** "Adaptations" means minor physical modifications to the home, adaptive equipment, and minor modifications to vehicles as specified in part 9505.3075.

Subp. 3. **Adult day care services.** "Adult day care services" means services provided to recipients by adult day care centers licensed under parts 9555.9600 to 9555.9730 and adult day care family homes established under Minnesota Statutes, sections 245A.01 to 245A.17.

Subp. 4. **Applicant.** "Applicant" means a person under age 65 or the representative of a person under age 65 who applies to participate in the community alternatives for disabled individuals program rather than enter a nursing home. Applicant also means a person or the representative of a person who has been admitted to a nursing home as a resident, but who has requested an assessment under part 9505.3025 to participate in the CADI program.

Subp. 5. **Assessment form.** "Assessment form" means the form supplied by the commissioner that is used to record the information required under parts 9505.2425, subpart 1, and 9505.3025.

Subp. 6. **Care plan or individual plan of care.** "Care plan" or "individual plan of care" means the written plan of a combination of services designed to meet the health and community-living needs of an applicant according to part 9505.3030.

Subp. 7. **Case management services.** "Case management services" means the services as specified in part 9505.3070 that identify, assist in gaining access to, authorize, and coordinate services for a recipient; monitor the delivery of services to the recipient; adjust services to the needs of the recipient; and advocate for the rights of the recipient to assure the health and safety of the recipient.

Subp. 8. **Case manager.** "Case manager" means a social worker employed by or under contract with the local agency, or a registered nurse who is employed by the local public health department or under contract with the local agency to provide case management. Local agency in this subpart means the local agency in the county of service.

Subp. 9. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Human Services or the commissioner's authorized representative.

Subp. 10. **Community alternatives for disabled individuals or CADI.** "Community alternatives for disabled individuals" or "CADI" means certain community-based services further described in parts 9505.3070 to 9505.3110 provided under a waiver to physically disabled individuals under the age of 65 who require the level of care provided in a nursing home. CADI services allow the persons to remain in their homes.

Subp. 11. **County of financial responsibility.** "County of financial responsibility" has the meaning given it in Minnesota Statutes, section 256G.02, subdivision 4.

Subp. 12. **County of service.** "County of service" means the county in which the applicant or recipient resides.

Subp. 13. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 14. **Directory of services.** "Directory of services" means the list of home and community-based services specified in part 9505.2395, subpart 17.

Subp. 15. **Extended home health services.** "Extended home health services" means the home health services specified in part 9505.3085.

Subp. 16. **Extended personal care services.** "Extended personal care services" means the personal care services specified in part 9505.3090.

Subp. 17. **Family.** "Family" means the persons who live with or provide informal care to a disabled individual. Family may include a spouse, children, friends, relatives, foster family, or in-laws.

Subp. 18. **Family support services; counseling and training.** "Family support services; counseling and training" means the services specified in part 9505.3095.

Subp. 19. **Formal caregivers.** "Formal caregivers" means persons or entities providing CADI services who are employed by or under contract with a local agency, or other agency or organization, public or private. Formal caregiver does not include case manager.

Subp. 20. **Home.** "Home" means the recipient's place of residence other than a nursing home. It includes a home owned or rented by the recipient, or a member of the recipient's family or foster family.

Subp. 21. **Home and community-based services.** "Home and community-based services" refers to services that provide adaptations and adult day care, case management, extended home health, extended personal care, family sup-

port, homemaker, independent living skills, respite care services, and medical supplies and equipment to a recipient through CADI.

Subp. 22. **Homemaker services.** "Homemaker services" means the services specified in part 9505.3100.

Subp. 23. **Independent living skills services.** "Independent living skills services" means supervision, training, or assistance to a recipient in self care, communication skills, socialization, sensory or motor development, reduction or elimination of inappropriate or maladaptive behavior, community living, and mobility that is provided by individuals or agencies qualified to provide independent living skills services.

Subp. 24. **Informal caregivers.** "Informal caregivers" means family, friends, neighbors, and others who provide services to and assist recipients without reimbursement for the services.

Subp. 25. **Lead agency.** "Lead agency" means the social service or public health agency approved by the county board to administer the CADI program.

Subp. 26. **Local agency.** "Local agency" means the county or multicounty agency authorized under Minnesota Statutes, section 256B.05, to administer the medical assistance program.

Subp. 27. **Medical assistance.** "Medical assistance" means the program including the CADI program established under title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

Subp. 28. **Mental illness.** "Mental illness" means, in the case of an adult, an illness as defined in Minnesota Statutes, section 245.462, subdivision 20, or, in the case of a child, an emotional disturbance as defined in Minnesota Statutes, section 245.4871, subpart 15.

Subp. 29. **Nursing home.** "Nursing home" means a facility, including a boarding care facility, licensed under Minnesota Statutes, chapter 144A, that is certified to participate in the medical assistance program.

Subp. 30. **Nursing home resident.** "Nursing home resident" means a person who lives, and expects to continue to live, in a nursing home for more than 30 days. For purposes of parts 9505.3010 to 9505.3140, nursing home resident does not include a person who is in a nursing home for respite care.

Subp. 31. **Person with mental retardation or a related condition.** "Person with mental retardation or a related condition" means a person as defined in part 9525.0015, subpart 20.

Subp. 32. **Personal care assistant.** "Personal care assistant" means a person who provides extended personal care services and meets the standards of part 9505.0335 or 9505.3090.

Subp. 33. **Physician.** "Physician" means a person who is authorized to practice medicine under Minnesota Statutes, chapter 147.

Subp. 34. **Preadmission screening or screening.** "Preadmission screening" or "screening" means the activities established under Minnesota Statutes, section 256B.091, subdivisions 1 to 4, and specified in part 9505.3025.

Subp. 35. **Preadmission screening team or team.** "Preadmission screening team" or "team" means the team defined in part 9505.2395, subpart 39, that is required under part 9505.3025 to assess the health and social needs of an applicant for CADI services.

Subp. 36. **Primary caregiver.** "Primary caregiver" has the meaning given it in part 9505.2395, subpart 40. The primary caregiver is designated by the recipient as his or her primary caregiver. Primary caregiver additionally means an informal caregiver of a recipient.

Subp. 37. **Public health nurse.** "Public health nurse" means a registered nurse who is qualified as a public health nurse under the Minnesota nurse practice act and employed by a public health nursing service as defined in subpart 38.

Subp. 38. **Public health nursing service.** "Public health nursing service" means the nursing program provided by a board of health under Minnesota Statutes, section 145.10, subdivision 1.

Subp. 39. **Reassessment.** "Reassessment" means the reevaluation of a CADI recipient's health and community-living needs under part 9505.3060.

Subp. 40. **Recipient.** "Recipient" means a person determined to be eligible for CADI services according to part 9505.3035, who chooses to receive the CADI services identified in the person's care plan, and whose services have been initiated.

Subp. 41. **Registered nurse.** "Registered nurse" means a person licensed under Minnesota Statutes, section 148.211.

Subp. 42. **Representative.** "Representative" means a person appointed by the court as a guardian or conservator under Minnesota Statutes, sections 252A.01 to 252A.21 or 525.539 to 525.6198; a spouse; a parent of a child under age 18 unless the parent's parental rights have been terminated; a person designated by a power of attorney or a durable power of attorney; or a person authorized by the applicant or recipient under part 9505.0015, subpart 8.

Subp. 43. **Resident class.** "Resident class" means the case mix classification assigned to a person as required under parts 9549.0058, subpart 2, and 9549.0059.

Subp. 44. **Respite care services.** "Respite care services" means short-term supervision, assistance, and care provided to a recipient, due to the temporary absence or need for relief of the primary caregiver.

Subp. 45. **Room and board costs.** "Room and board costs" means costs of providing food and shelter to a recipient including the identifiable direct costs of:

A. private and common living space;

B. normal and special diet food preparation and service;

C. linen, bedding, laundering, and laundry supplies;

D. housekeeping including cleaning and lavatory supplies;

E. maintenance and operation of buildings and grounds, including fuel, electricity, water, supplies, and parts and tools to repair and maintain equipment and facilities; and

F. salaries and other costs related to items A to E.

Subp. 46. **Skilled nursing service.** "Skilled nursing service" means the term defined in Code of Federal Regulations, title 42, section 405.1224.

Subp. 47. **Slot.** "Slot" means an opening available for services to a recipient under the waiver.

Subp. 48. **Social worker.** "Social worker" means a person who has met the minimum qualifications of a social worker under the Minnesota Merit System or a county civil service system in Minnesota.

Subp. 49. **State medical review team.** "State medical review team" means a team consisting of physicians and social workers who are under contract with or employed by the department to review a medical and social history to determine whether a person is disabled under the regulations of the Social Security Administration.

Subp. 50. **Vehicle.** "Vehicle" means a vehicle owned by the recipient or a member of the recipient's family or foster family that is used to transport a recipient with sensory or mobility defects.

Subp. 51. **Waiver.** "Waiver" means the document approved by the United States Department of Health and Human Services which allows the state to pay for home and community-based services authorized under Code of Federal Regulations, title 42, part 441, subpart G. The term includes all amendments to the waiver including any amendments made after the effective date of parts

9505.3010 to 9505.3140, as approved by the United States Department of Health and Human Services.

Subp. 52. **Waiver year.** "Waiver year" means October 1 to the following September 30.

Subp. 53. **Working day.** "Working day" has the meaning given it in part 9505.2395, subpart 56.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3020 PREADMISSION SCREENING OF CADI APPLICANTS.

Preadmission screening is required for all applicants for home and community-based services under CADI. The screening must incorporate the requirements of the 1987 Omnibus Budget Reconciliation Act, Public Law Number 100-203, about appropriate nursing home placement for persons with mental illness and for persons with mental retardation or related conditions.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3025 DUTIES OF PREADMISSION SCREENING TEAM.

Subpart 1. **General procedure for preadmission screening.** The preadmission screening team of the county of service must conduct the preadmission screening of a CADI applicant as specified in parts 9505.2425, subparts 1; 2; 3, items A, B, C, and D; 4; and 14; and 9505.3020. Additionally, the preadmission screening team must:

A. inform the applicant about eligibility requirements for CADI as specified in part 9505.3035 and the services available through CADI;

B. give the person who is not a medical assistance recipient a medical assistance application and help the person complete the medical assistance application as required under parts 9505.0010 to 9505.0150; and

C. in the case of an applicant applying on or after October 1, 1989, who was not a nursing home resident on October 1, 1989, inform the applicant about the right of the applicant and the applicant's spouse to retain assets up to the amount specified in Minnesota Statutes, section 256B.059.

Subp. 2. **Local agency data sharing with lead agency.** Upon the lead agency's request, the local agency must provide the lead agency with information the local agency has concerning the medical assistance eligibility or social service needs of an applicant.

Subp. 3. **Team recommendations for CADI applicants.** After completing the assessment form required under part 9505.2425, subpart 1, and the assessment interview required under part 9505.2425, subpart 2, the team must recommend one of the choices in items A to E.

A. The team must recommend admission to a nursing home when:

(1) the assessment indicates that the applicant needs the level of care provided by a nursing home and that the home and community-based services that the applicant would need in lieu of nursing home care are not currently available; or

(2) the assessment indicates that the anticipated cost to medical assistance of providing the needed home and community-based services and medical assistance home care services would exceed the limit specified in part 9505.3040.

B. The team must recommend continued stay in a nursing home when:

(1) the assessment indicates that the resident needs the level of care provided by a nursing home and that the home and community-based services that the resident would need in lieu of nursing home care are not currently available; or

(2) the assessment indicates that the anticipated cost to medical assistance of providing the needed home and community-based services and medical assistance home care services would exceed the limit specified in part 9505.3040.

C. The team must recommend health and social services including CADI services and, if needed, medical assistance home care services when the assessment indicates that the applicant needs the level of care provided by a nursing home; the services needed by the applicant to be at home are available or can be developed; and the anticipated cost of providing the services is within the limit specified in part 9505.3040.

D. The team must recommend health and social services including CADI services and, if needed, medical assistance home care services when the assessment indicates that the applicant who is a nursing home resident needs the level of care provided by a nursing home; the home and community-based services needed by the applicant are available or can be developed; and the anticipated cost of providing the necessary services is within the limit specified in part 9505.3040.

E. The team must recommend that the applicant live in the community without home and community-based services if the assessment indicates that the person is not an applicant to or resident of a nursing home, does not require nursing home care, or does not need home and community-based services.

Subp. 4. **Application for CADI services; request for case manager.** If the team recommends the use of home and community-based services and the applicant chooses to remain in the community with the recommended services, the team must request that the person complete and sign an application for home and community-based services under CADI. To be eligible to receive CADI services, the person must also be eligible for medical assistance. If the person's eligibility for medical assistance has not been determined, a financial worker may accompany the team to the screening to take an application for medical assistance. If the applicant signs the application for home and community-based services under CADI, the preadmission screening team must notify the lead agency and request the lead agency to assign a case manager.

Subp. 5. **Notice of preadmission screening team recommendation.** The preadmission screening team must give notice of the team recommendation made under subpart 3 as specified in part 9505.2425, subpart 8. Additionally, the team must obtain the consent of the applicant or, if appropriate, the applicant's representative for the purpose of notifying the applicant's physician.

Subp. 6. **Information to county of financial responsibility.** If the county of service is different from the county of financial responsibility, the preadmission screening team of the county of service must submit information about the applicant to the county of financial responsibility within ten working days after the preadmission screening is completed. The information must include:

A. a copy of the preadmission screening document;

B. a copy of the signed application required in subpart 4;

C. a copy of the preadmission screening assessment form;

D. a copy of the care plan as specified in part 9505.3030 that includes services to be provided and the estimated monthly cost of services; and

E. the person's medical assistance eligibility status.

Subp. 7. **County of financial responsibility action.** The county of financial responsibility shall review the information submitted by the preadmission screening team of the county of service and keep a file on the CADI applicant. The county of financial responsibility must sign off on the care plan and approve the application no later than ten days after receiving the information if the applicant meets the eligibility requirements in part 9505.3035 and has been assigned a slot by the department. Disputes about the county of financial responsibility must be resolved according to Minnesota Statutes, section 256G.09.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3030 INDIVIDUAL CARE PLAN.

Subpart 1. **Care plan development.** The case manager must develop a care plan on a form provided by the commissioner for an applicant who has chosen to remain in or return to the community and who is eligible for CADI services under parts 9505.3010 to 9505.3140. The case manager must develop the plan in consultation with:

A. the applicant;

B. the applicant's representative, if any; and

C. with the applicant's consent:

(1) the applicant's family;

(2) the primary caregiver if applicable;

(3) the applicant's physician; and

(4) any other individuals who are currently involved in meeting the applicant's health or community-living needs.

Subp. 2. **Care plan contents.** The care plan must include:

A. care objectives;

B. prescriptions for medications, restorative or rehabilitative services, diet, special procedures, and other health or community-living services recommended for the health or safety of the applicant;

C. a description of the health care and social services necessary to maintain the person in the community;

D. the frequency, scope, and duration of each of the services;

E. the designation of who will deliver each of the services described in the plan including both formal and informal providers;

F. the schedule for review and evaluation of the care plan;

G. an estimate of the total monthly cost of CADI and medical assistance services identified and recommended by the team as specified under part 9505.3025, subpart 3; and

H. the payment source for each service.

Subp. 3. **Directory of services.** In developing the recipient's care plan, the case manager must use the directory of services as specified in part 9505.2425, subpart 7.

Subp. 4. **Signatures on care plan.** The case manager shall request the applicant to sign the care plan specified in subpart 2 as an indication of the applicant's acceptance of the care plan. Additionally, the case manager must sign the care plan and, if authorized as in subpart 5, item D, request the recipient's physician to sign the recipient's care plan.

Subp. 5. **Distribution of care plan.** The case manager must give a copy of the applicant's or recipient's care plan to:

A. the county of service;

B. the county of financial responsibility;

C. the applicant or recipient; and

D. with the consent of the applicant or recipient, or the representative of the applicant or recipient, to the applicant's or recipient's physician and the provider or providers of the CADI services specified in the applicant's or recipient's care plan.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3035 ELIGIBILITY FOR CADI SERVICES.

Subpart 1. **Eligibility criteria.** A person is eligible for CADI services if the person meets the criteria in items A to L:

A. The person has been screened according to part 9505.3025.

B. The person is under age 65.

C. The person has been certified as disabled by the Social Security Administration or the state medical review team.

D. The person is a medical assistance recipient or is eligible for medical assistance under subpart 2 or parts 9505.0010 to 9505.0150.

E. The person would need the level of care provided in a nursing home if home and community-based services are not available.

F. The person is a nursing home applicant who chooses to remain in the community and use home and community-based services or is a nursing home resident who chooses to leave the nursing home and use home and community-based services.

G. The health and safety of the person is assured by providing home and community-based services.

H. The service needed by the person is not already provided as a part of a residential placement agreement. A residential services provider shall not provide CADI or medical assistance services without prior authorization from the commissioner. For purposes of this item, "residential placement agreement" means an agreement to provide a supervised living arrangement for the recipient, such as a foster care agreement between the county board and the provider. The recipient's case manager must document in the recipient's care plan all services to be provided to the recipient as part of the residential placement agreement. The term does not apply to residence in a long-term care facility.

I. The person needs community services that cannot be funded by sources other than CADI.

J. The cost of all CADI services and medical assistance funded nursing, home health aide, and personal care services including the supervision of personal care assistants; authorized in the care plan is less than the limitation in part 9505.3040.

K. The applicant or recipient accepts case management services.

L. The person has a written plan of care approved by the commissioner under part 9505.3055, subpart 1.

Subp. 2. **Determination of CADI applicant's medical assistance eligibility.** A CADI applicant's medical assistance eligibility must be determined under parts 9505.0010 to 9505.0150 except as specified in items A and B. For purposes of this subpart, "spend-down" has the meaning given in part 9505.0015, subpart 44.

A. The local agency shall determine the applicant's eligibility for medical assistance without considering parental or spousal income and assets if the person meets the criteria in subpart 1, items A to L.

B. If an applicant's income exceeds the limits for medical assistance eligibility, the cost of CADI services and other medical services needed by the applicant must be used to meet the spend-down required under part 9505.0065, subpart 11. The cost of a CADI service is considered to be incurred on the first day of the month in which the service is provided. The costs of other health services are applied to the spend-down requirement as of the day on which the service is given. The applicant is responsible for paying bills used to meet the spend-down.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3040 LIMIT ON COSTS OF RECIPIENT'S CADI SERVICES.

Subpart 1. **Costs to be applied toward the cost limit of a recipient's CADI services.** Except as provided in subpart 2, the costs of the following items must be applied toward the cost limit of a recipient's CADI services in subpart 3. The costs must be applied as specified in part 9505.3035, subpart 2:

A. costs of all CADI funded services, including case management, medical supplies and equipment, and adaptations; and

B. costs of home care services reimbursed by medical assistance.

Subp. 2. **Service costs to be excluded.** If reimbursed by medical assistance, the costs of the following items must be excluded from the costs included under subpart 1 to the extent that costs of these items are reimbursed by medical assistance:

A. prescription drugs;

B. medical transportation;

C. audiology, speech-language-pathology, respiratory, occupational, and physical therapy; and

D. medical supplies and equipment.

Subp. 3. **Monthly limit on costs of recipient's CADI services.** Except as provided in subpart 4, the monthly cost of CADI services to a recipient shall not exceed the statewide monthly average nursing home rate effective July 1 of the fiscal year in which the cost is incurred less the statewide average monthly income of nursing home residents who are less than age 65 and are medical assistance recipients in the month of March of the previous Minnesota fiscal year. In calculating the monthly limit for a recipient, the statewide monthly average nursing home rate shall be the rate of the resident class to which the recipient would be assigned under parts 9549.0050 to 9549.0059.

Subp. 4. **Exception to monthly limit on costs of recipient's CADI services.** If medical supplies and equipment or adaptations are or will be purchased for the recipient, the costs that are not reimbursable by medical assistance must be prorated on a monthly basis throughout the waiver year in which they are purchased. If the monthly cost of a recipient's other CADI services exceeds the limit in subpart 3, the annual cost of the CADI services shall be determined. In this event, the annual cost of CADI services to a recipient shall not exceed 12 times the monthly limit calculated under subpart 3.

Subp. 5. **Monthly limits on costs of CADI services of applicant who is a nursing home resident.** The monthly cost of CADI services for a person who is a nursing home resident at the time of requesting a determination of eligibility for CADI shall not exceed the monthly payment for the resident class assigned under parts 9549.0050 to 9549.0059 for that resident in the nursing home where the resident currently resides.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3045 REQUEST FOR PROVISIONAL CADI SLOT ASSIGNMENT.

When the case manager has completed a care plan as specified in part 9505.3030 and has determined that the applicant or recipient meets the requirements of part 9505.3035, the case manager must contact the commissioner by phone and request the provisional assignment of a CADI slot pending the commissioner's determination under part 9505.3055. The request must include the following information:

A. the applicant's name;

B. the applicant's birth date;

C. the applicant's medical assistance ID number;

D. the applicant's resident class as specified in part 9505.3040, subpart 3;

E. the approximate date that services will begin; and

F. the estimated average monthly cost of home and community-based services funded by medical assistance and CADI.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3050 WRITTEN REQUEST FOR CADI SLOT ASSIGNMENT.

No later than 15 days after receiving a provisional CADI slot assignment under part 9505.3045, the lead agency must send to the commissioner a copy of the information specified in part 9505.3025, subpart 6, items A and D. If the required information is not submitted within the 15-day period, the department shall withdraw the provisional CADI slot assignment if there are other applicants eligible under part 9505.3035 who are waiting for a slot to be assigned. The department shall notify the lead agency if a provisional CADI slot assignment is ended.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3055 COMMISSIONER'S DETERMINATION.

Subpart 1. **Review and notice of decision.** The commissioner shall review the information and documents submitted by the lead agency under part 9505.3050 to determine whether the applicant is eligible for and approved to receive home and community-based services that are specified in the applicant's care plan and that are available under and paid for through CADI.

Subp. 2. **Criteria for commissioner's approval and assignment of CADI slot.** The commissioner shall approve a request for CADI services and assign a CADI slot in the order in which the application required under subpart 1 is received if the applicant meets the eligibility criteria in part 9505.3035 and a CADI slot is available.

Subp. 3. **Disapproval of request for CADI services.** The commissioner shall disapprove a request for CADI services if the applicant does not meet the eligibility criteria in part 9505.3035, a CADI slot is not available, or the information and documents submitted by the lead agency under part 9505.3050 are incomplete. If the information and documents submitted by the lead agency under part 9505.3050 are incomplete, the commissioner shall notify the lead agency of the action necessary to complete the application.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3060 REASSESSMENT OF CADI RECIPIENT.

Subpart 1. **Reassessment required.** The case manager must conduct a face-to-face reassessment of the health care needs of a CADI recipient at least once every six months after home and community-based services have begun. In addition to the six-month assessments, the case manager must reassess the health care needs of a CADI recipient when:

A. the case manager determines that changes in the health or community-living needs of the CADI recipient or changes in informal support arrangements necessary to remain at home require revisions in the recipient's care plan; or

B. a person who is eligible for CADI services has entered a nursing home for other than respite care or has entered a hospital for a temporary stay and is ready to return to the community.

Subp. 2. **Reassessment procedure.** The case manager must reassess the recipient as required under subpart 1 using the procedures specified for a preadmission screening in part 9505.3025.

Subp. 3. **Record of reassessment.** The case manager must place a record of the recipient's reassessment in the recipient's records at the lead agency. The record shall include the reason or reasons for the reassessment, the names of the persons consulted during the reassessment and their relationship to the recipient, revisions of the care plan and the reason or reasons for each revision or a statement that revisions were not needed. The revised care plan or statement must be signed by the recipient's physician.

Subp. 4. **Distribution of revised care plan.** The case manager must give a copy of the recipient's revised care plan to the entities specified in part 9505.3030, subpart 5.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3065 REIMBURSEMENT FOR CADI SERVICES.

The services in items A to J, as specified in parts 9505.3070 to 9505.3110, shall be reimbursed on a fee-for-service basis under CADI, if the services are provided according to a recipient's care plan, if the services are necessary to avoid the recipient's institutionalization, and if the rates for the services comply with the rates established in part 9505.3135:

A. case management services;

B. homemaker services;

C. respite care services;

D. adult day care services;

E. extended home health services;

F. extended personal care services;

G. adaptations;

H. independent living skills services;

I. family support services; and

J. other services if authorized under the waiver.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3068 COSTS NOT ELIGIBLE FOR REIMBURSEMENT UNDER CADI.

The costs of the following services shall not be reimbursed under the CADI program:

A. community services that can be reimbursed through other funding sources including Medicare and third-party payers as defined in part 9505.0015, subpart 46;

B. room and board costs except for respite care provided away from the recipient's residence;

C. services of providers who are not under contract with the county;

D. respite care services that exceed the 720-hour limit in part 9505.3110;

E. adaptations that cost more than allowed by the waiver per recipient;

F. services not authorized by the case manager;

G. supplementary or replacement services covered by a Medicare or medical assistance funded hospice program, except services for a condition not related to the terminal illness; or

H. payment for CADI services provided to a nursing home resident before the date of discharge from the nursing home.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3070 CASE MANAGEMENT SERVICES.

Subpart 1. **Case management services required.** Case management services are required under CADI. The lead agency must assure that a case manager is designated to provide case management services to each recipient.

Subp. 2. **Case manager qualifications.** Case management services must be provided by a registered nurse as defined in part 9505.3015, subpart 41, or a social worker as defined in part 9505.3015, subpart 48.

A person who provides case management services must be employed by or under contract with the lead agency. The lead agency shall monitor and enforce compliance with the terms of the contract.

Subp. 3. **Responsibilities of case manager.** The case manager must:

A. assure that the team uses the criteria of the Preadmission Screening Assessment document in screening applicants;

B. develop the care plan with the screening team, the applicant, and the applicant's family members and other appropriate persons;

C. obtain the necessary documentation of service need, including the attending physician's signature;

D. authorize the provision of services specified in the recipient's approved case plan;

E. monitor service providers and the provision of services to ensure that only the authorized care is being provided and that the recipient's health and safety at least is being maintained;

F. with the consent of the applicant or recipient or the representative of the applicant or recipient, initiate and maintain contact with family members and other informal caregivers to ensure that planned care, both formal and informal, is being provided;

G. assist the recipient in gaining access to needed medical, social, educational, and other services;

H. reassess a CADI recipient as required under part 9505.3060;

I. complete a notice of action form (DHS-2828) if the recommendations of the preadmission screening team following a reassessment under part 9505.3060 are to reduce, suspend, or terminate the recipient's CADI services. The original notice of action must be sent to the recipient no later than ten days before the proposed action;

J. monitor the recipient's health and safety;

K. contact the local agency to verify that the person is eligible for medical assistance; and

L. provide ongoing coordination of the care plan so the cost does not exceed cost limits of part 9505.3040.

Subp. 4. **Reporting suspected abuse or neglect of a vulnerable adult or suspected maltreatment of a child.** A case manager who has reason to believe a recipient who is an adult is or has been subject to abuse or neglect as defined in Minnesota Statutes, section 626.557, subdivision 2, must immediately comply with the reporting and other actions required under Minnesota Statutes, section 626.557. A case manager who has reason to believe a recipient, who is a child, is or has been subject to maltreatment as defined in Minnesota Statutes, section 626.556, must immediately comply with the reporting and other actions required under Minnesota Statutes, section 626.556. The case manager must determine how to assure the recipient's health and safety during the investigation, and may take one or more of the actions specified in subpart 5. The case manager must request a report from the protection agency in order to take the action required in subpart 5 unless the recipient's health and safety is imminently threatened.

Subp. 5. **Case manager decisions.** When the case manager receives the findings of the investigation conducted under Minnesota Statutes, section 626.556

or 626.557, the case manager shall amend the care plan as needed to assure the recipient's health and safety. Based on the findings, the case manager shall determine whether:

A. to arrange for the services of another CADI provider;

B. to work out alternative housing and services for the recipient; or

C. to suspend or terminate the CADI services. Notwithstanding any rule to the contrary, if the case manager decides to suspend or terminate the recipient's CADI services, the suspension or termination shall take effect upon the date of the notice of the suspension or termination to the recipient.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3075 ADAPTATIONS.

An adaptation is available to a recipient under CADI only if the adaptation is necessary to enable a recipient with mobility problems, sensory deficits, or behavior problems to be maintained at home. Adaptations include minor physical adaptations to the home, adaptive equipment, and minor adaptations to vehicles provided to enable disabled persons to live in the community. Examples of adaptations to the home are widened doors, handrails, lifting devices, and ramps. Examples of adaptations to a vehicle are lifting devices, wheel chair securing devices, and adapted seats. For purposes of this part, "minor physical adaptation" means an adaptation that costs less than the limit specified in the waiver. Adaptations can be provided under the CADI waiver for a recipient if:

A. the adaptation is not available from any other funding source and has a cost within the limitations specified in parts 9505.3010 to 9505.3140; and

B. the case manager has received prior authorization from the commissioner. To obtain authorization, the case manager must document that the adaptation is necessary for the recipient to avoid nursing home admission and the cost of the adaptation is within the limit specified in the waiver.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3080 ADULT DAY CARE SERVICES.

Adult day care services are available under CADI. Adult day care services are to be offered only when the services are necessary to avoid the recipient's admission to a nursing home. Adult day care services provided through CADI must meet the criteria in items A and B.

A. The services must be furnished on a regularly scheduled basis and cannot exceed 12 hours in a 24-hour period.

B. If the adult day care service provides transportation, then the cost of transportation to and from the site of the adult day care service is eligible for payment under CADI if it is included in the day care rate.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3085 EXTENDED HOME HEALTH SERVICES.

Extended home health services are available under CADI if the services meet the requirements in items A to C.

A. The service is a home health service as specified in part 9505.0295 except that the limits in subpart 3 of part 9505.0295 on the number of visits and hours eligible for medical assistance reimbursement do not apply.

B. The service is provided according to the amount, duration, and scope specified in the recipient's care plan.

C. The service is provided by a provider who meets the requirements of part 9505.0290, subpart 2.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3090 EXTENDED PERSONAL CARE SERVICES.

Subpart 1. **Availability under CADI.** Extended personal care services are available under CADI if the extended personal care services meet the requirements in part 9505.0335 except as provided in subparts 2 and 3 and except that the directions for the recipient's care may be provided by a primary caregiver or family member if the recipient is not able to direct his or her own care.

Subp. 2. **Qualification as personal care assistant.** A person who does not qualify as a personal care assistant under part 9505.0335 can be a personal care assistant for a recipient if the person meets the training requirements under part 9505.0335, subpart 3, and is employed by or under contract with the lead agency.

Subp. 3. **Relative as personal care assistant.** A recipient's relative, other than a responsible relative as defined in part 9505.0015, subpart 43, may be employed as a personal care assistant if the relative meets the requirements in subpart 2, is under contract with the lead agency, and meets one of the financial hardship criteria in items A to D:

A. the relative resigns from a full-time job to care for the recipient;

B. the relative goes from a full-time to a part-time job with less compensation;

C. the relative takes a leave of absence without pay to provide personal care for the recipient; or

D. the relative, because of local labor conditions, is the only person available to provide care for the recipient.

Subp. 4. **Commissioner's approval of extended personal care services.** The lead agency must obtain the department's approval to provide extended personal care services to a recipient.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3095 FAMILY SUPPORT SERVICES.

Subpart 1. **Availability as CADI service.** Family support services that are the training and counseling services in items A and B are available under CADI. The services may be provided to the recipient as well as to persons with whom the recipient lives or who routinely are the recipient's informal caregivers.

A. Training must be designed to increase the recipient's or family member's ability to care for the recipient at home and must be necessary to avoid the recipient's admission to a nursing home. Training includes instruction about the use of equipment and treatment regimens that are specified in the recipient's care plan.

B. Counseling includes helping the recipient or members of the recipient's family with crises, coping strategies, and stress reduction as required for family functioning to maintain the recipient in the community.

Subp. 2. **Standards to be a CADI provider of training services.** A provider of training services under CADI must meet the applicable qualification specified in items A to H.

A. A physician must be licensed to practice in Minnesota.

B. A registered nurse must be licensed and have one year of experience as a professional nurse.

C. A physical therapist must have a current Minnesota certificate of registration.

D. An occupational therapist must be currently certified by the American Occupational Therapy Association as an occupational therapist.

E. A respiratory therapist must meet the criteria established for a respiratory therapist in part 9505.0295, subpart 2, item E.

F. A medical equipment supplier must be authorized by the case manager to provide training in use of equipment and must be a provider under part 9505.0195.

G. A speech-language pathologist must be certified by the American Speech-Language-Hearing Association.

H. A nutritionist must have a bachelor's degree and be registered by the Commission on Dietetic Registration.

Subp. 3. **Standards for providers of family support counseling services.** A provider of family support counseling services must be one of the following:

A. a Medicaid enrolled psychiatrist or individual who works under the supervision of a Medicaid enrolled psychiatrist;

B. a Medicaid enrolled psychologist or individual who works under the supervision of a Medicaid enrolled psychologist;

C. a mental health clinic that is an enrolled Medicaid provider;

D. a social worker licensed under Minnesota Statutes, sections 148B.18 to 148B.28; and

E. an independent practitioner who provides counseling services and who has been determined by the lead agency to:

(1) have a general knowledge of disabilities and chronic illnesses that may affect individual or family functioning;

(2) have skills in mental health assessment, including client interviewing and screening;

(3) have skills in mental health management including treatment planning, general knowledge of social services, record keeping, reporting requirements, confidentiality rules, and any federal or state regulations which apply to mental health services;

(4) have skills in individual and group counseling, including crisis intervention; and

(5) provide proof that:

(a) The individual possesses at least a bachelor's degree with a major in social work, nursing, sociology, human services, or psychology and has successfully completed 960 hours of experience as a counselor supervised by a licensed psychiatrist or psychologist. The experience can be either as a student, volunteer, or employee.

(b) The individual has successfully completed a minimum of:

i. 40 hours of classroom training in a health related field;

ii. 40 hours of classroom training in mental health assessment including interviewing skills;

iii. 40 hours of classroom training in mental health management including treatment planning, social services, record keeping, reporting requirements, and confidentiality;

iv. 40 hours of classroom training in individual and group counseling techniques; and

v. successful completion of 960 hours of experience as a counselor supervised by a licensed psychiatrist or licensed psychologist as either a student, volunteer, or employee; or

(c) The individual possesses training in unit (b), subunits (i) to (iii), and has successfully completed two years of supervised experience as a counselor or therapist.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3100 HOMEMAKER SERVICES.

Subpart 1. **Availability as CADI service.** Homemaker services are available under CADI. Homemaker services must be designed to enable a recipient to remain at home and avoid admission to a nursing home and must be provided if authorized by the case manager.

Subp. 2. **Tasks of homemaker.** Homemaker services include:

A. house cleaning;

B. laundering and ironing;

C. meal planning and preparation;

D. dishwashing;

E. household management;

F. providing companionship, emotional support, and social stimulation;

G. observing and evaluating home safety practices and improving these practices where appropriate;

H. monitoring the safety and well being of the recipient; and

I. performing essential errands and shopping.

Subp. 3. **Qualified homemakers.** The lead agency shall assure that each recipient receiving homemaker services is served by a homemaker qualified under part 9565.1200, subpart 2.

Subp. 4. **Contracting for homemaker services and supervision.** The lead agency may directly provide or contract for homemaker services for a recipient as indicated in the recipient's care plan. If the lead agency provides homemaker services directly, the lead agency must also provide supervision of the homemaker's activities. If the lead agency contracts with a provider for homemaker services, the provider must meet the requirements of Minnesota Statutes, sections 144A.43 to 144A.46.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3105 INDEPENDENT LIVING SKILLS SERVICES.

Subpart 1. **Availability as CADI services.** Independent living skills services are available under CADI. Independent living skills services may be provided in the disabled person's home or at a site approved by the case manager. Independent living skills services must be directed at the development and maintenance of community living skills and community integration.

Subp. 2. **Standards for providers of independent living skills services.** Providers of independent living skills services may include the following:

A. home health agencies enrolled as Medicaid providers;

B. rehabilitation agencies enrolled as Medicaid providers;

C. a person who is employed by an independent living center and who is determined by the lead agency to meet the requirements in subitems (1) to (5). For purposes of this item, "independent living center" means a center that meets the requirements of parts 3300.3100 to 3300.3270.

(1) has general knowledge of disabilities and chronic illnesses which affect an individual's ability to live independently in the community;

(2) has the ability to do a needs assessment of the skills a disabled individual must develop in order to live independently in the community;

(3) has knowledge of independent living skills management including service planning, general knowledge of social services, record keeping, reporting requirements, and confidentiality;

(4) has the ability to provide assistance, supervision, and training in the area of independent living; and

(5) provides proof that the person:

(a) has a bachelor's degree with a major in nursing, physical therapy, occupational therapy, or speech-language pathology, psychology, or sociology, and has successfully completed 480 hours of experience working with disabled or chronically ill individuals as a student, volunteer, or employee, under the supervision or direction of a licensed physician;

(b) has successfully completed an accredited educational program for registered nurses or licensed practical nurses;

(c) has completed a nursing assistant training program or its equivalent for which competency as a nursing assistant is determined by the State Board of Vocational Technical Education;

(d) has completed a homemaker or home health aide preservice training program using a curriculum recommended by the Minnesota Department of Health and whose supervisor has determined that the individual has the skills required to provide the independent living skills services as stated in the care plan; or

(e) has received a minimum of:

i. five hours of classroom training in recognizing the symptoms and effects of certain disabilities and health conditions;

ii. 20 hours of classroom instruction in providing supervision of, training to, and assistance with independent living skills services; and

iii. a determination by the person's supervisor that the individual has the skills required to provide the independent living skills services stated in the care plan.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3107 MEDICAL SUPPLIES AND EQUIPMENT.

Subpart 1. **Availability as a CADI service.** Medical supplies and equipment are available as one of the extended home health services under CADI. The lead agency may buy or rent care-related medical supplies and equipment for a recipient if the medical supplies and equipment are specified in the recipient's approved care plan and are beyond the amount, scope, and duration available as covered services under parts 9505.0170 to 9505.0475; and the case manager has received prior authorization from the commissioner to use CADI funds.

Subp. 2. **Criteria to obtain commissioner's prior authorization.** To obtain prior authorization, the case manager must document that the medical supply or equipment is necessary to enable the recipient to remain in the community and is beyond the amount, scope, and duration available as a covered service under parts 9505.0170 to 9505.0475; and the cost of the medical supply or equipment is within the limitation specified in the waiver. "Prior authorization" means the commissioner's approval given to a lead agency before the lead agency purchases or rents the item.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3110 RESPITE CARE SERVICES.

Subpart 1. **Availability as CADI service.** Respite care services are available under CADI. Respite care is limited to 720 hours per person per waiver year.

Subp. 2. **Provider standards.** Respite care may be provided in either an out-of-home setting or in the recipient's own home.

A. Out-of-home respite care must be provided in a facility approved by the county such as a hospital, nursing home, foster home, or community residential facility. When respite care is provided in a non-Medicaid certified facility, that facility must meet applicable state licensure standards.

B. In-home respite care providers must be individuals who meet the state qualifications required of registered or licensed practical nurses, home health aides, or personal care assistants who have been specifically trained to provide care to the recipient. Respite care workers must have had first-aid training and cardiopulmonary resuscitation training. A respite care worker who is a home health aide or personal care assistant must be under the supervision of a registered nurse. The registered nurse must assure that the respite care worker is able to read and follow instructions, able to write clear messages, and has a level of skill required by the recipient's needs.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3115 STANDARDS FOR PROVIDER REIMBURSEMENT.

Lead agencies must assure that providers of all CADI services are qualified under parts 9505.0170 to 9505.0475 and 9505.3010 to 9505.3140 to provide the necessary service. In addition, a provider shall receive reimbursement for CADI services only if the provider meets the criteria in items A to D.

A. The provider must have current Minnesota certification or licensure for the specific CADI service if Minnesota Statutes or Minnesota Rules require certification or licensure.

B. The provider must assure that the provider and all employees or subcontractors meet the standards established in the waiver that apply to the services provided or in Minnesota Statutes, chapters 144A, 146, and 148; parts 9505.0170 to 9505.0475; and Code of Federal Regulations, title 42, sections 440.180 and 440.300 to 440.310.

C. The provider must be employed by or have contracted with the lead agency to provide CADI services.

D. The provider must be reimbursed only for services authorized by the case manager as part of the recipient's care plan.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3120 LEAD AGENCY SELECTION OF CADI PROVIDERS.

Subpart 1. **Solicitation of providers.** The lead agency must solicit providers for all CADI services. The solicitation may be by written notice, a request for proposal, or as part of the annual public meeting required by Minnesota Statutes, section 256B.091, subpart 8, and part 9505.2460, subpart 1. If the lead agency chooses to use a written notice, the lead agency must place the notice in the newspaper that is the official newspaper designated by the county board of commissioners of the local agency under Minnesota Statutes, section 279.08. The notice must state the type of services for which a need is anticipated, the criteria in subpart 2 for selection as a CADI provider, the date by which the lead agency will complete its selection of CADI providers, and the name, telephone number, and address of the lead agency's contact person who can provide information about the criteria for selection and contract terms.

Subp. 2. **Selection factors.** The lead agency must contract with all providers that meet the standards to provide CADI services under parts 9505.3010 to 9505.3140. The lead agency must consider items A to G:

A. the need for the particular service offered by the provider;

B. the ability of the provider to meet the service needs of CADI recipients in the county;

C. the geographic area to be served by the provider;

D. the quality assurance methods to be used by the provider including compliance with required licensure, certifications, or standards and supervision of employees as required by parts 9505.3090 to 9505.3120;

E. the provider's agreement to provide the CADI service at a fee that is at or less than the county's maximum reimbursement rate for the service;

F. services previously or currently delivered by the provider; and

G. the provider's previous compliance with contract provisions and the provider's future ability to comply with contract provisions including billing requirements, and terms related to contract cancellation and indemnification.

Subp. 3. **Written record of reason for not selecting a provider.** A lead agency must keep a written record of the reason a provider who requests a contract to provide CADI services was not selected and must notify the provider of the reason.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3125 CONTRACTS FOR CADI SERVICES.

Subpart 1. **Contract required.** To receive reimbursement for CADI services, the provider must be employed by or have a contract with the lead agency.

Subp. 2. **Compliance with applicable laws and regulations required.** The lead agency must have a medical assistance provider agreement according to part 9505.0195. The lead agency and any provider of services under parts 9505.3010 to 9505.3140 that is employed by or under contract to the lead agency must comply with Code of Federal Regulations, title 42; Minnesota Statutes, chapter 256B; and all applicable department rules relating to medical assistance providers.

Subp. 3. **Information required in contract.** The contract must contain:

A. the estimated number of CADI recipients to be served by the provider;

B. an agreement to comply with parts 9505.3010 to 9505.3140;

C. an agreement to comply with the Minnesota Government Data Practices Act;

D. the beginning and ending dates for the term of the contract;

E. an agreement to comply with the care plan as set forth by the case manager;

F. the amount that the lead agency shall pay the provider for the services;

G. the conditions under which the lead agency shall terminate the provider's contract;

H. documentation of an individual abuse prevention plan that complies with parts 9555.8000 to 9555.8500 in the case of adults or with parts 9560.0210 to 9560.0234 in the case of children;

I. a description of the reports the provider must give the lead agency;

J. a description of the records the provider must keep; and

K. other provisions the county board determines are needed to ensure the county's ability to comply with part 9525.1900.

Subp. 4. **Subcontracts.** If the provider subcontracts with another contractor the provider must:

A. have written permission from the lead agency to subcontract;

B. ensure that the subcontractor meets all the requirements of subparts 2 and 3 in the same manner as those requirements apply to all providers; and

C. ensure that the subcontractor performs fully the terms of the subcontract.

Subp. 5. **Noncompliance.** If the provider or subcontractor fails to comply with the contract, the lead agency must notify the local agency and request the county board to take appropriate action. Upon receiving the request, the county

board shall seek any available legal remedy. The county board shall notify the commissioner in writing within 30 days of receiving information that provides the county board with reasonable grounds to believe that a contract required under this part has been breached in a material manner or that a provider or subcontractor has taken any action or failed to take any action that constitutes anticipatory breach of the contract. The county board may allow the provider or subcontractor a reasonable amount of time to cure the breach or anticipatory breach. The county board shall notify the commissioner in writing within ten working days if the provider or subcontractor takes any action or fails to take any action in response to the opportunity to cure. In the notice, the county board shall inform the commissioner of the action the county board intends to take.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3130 AGENCY REPORTS AND RECORDS.

Subpart 1. **County plans.** The lead agency must submit an annual county plan for CADI services on forms provided by the commissioner. The lead agency must submit the county plan to the commissioner by August 1 of each year for the lead agency to receive reimbursement for CADI services during the next waiver year. The lead agency must submit revisions of the county plan to the commissioner for approval before implementing the revisions. The submitted plan or a revision of a plan must be signed by the person authorized by the county board. The county plan must include items A to J:

A. name and address of the lead agency;

B. name, address, and telephone number of the administrative contact within the lead agency;

C. a description of how the agency will make sure that the actual cost of services per individual per waiver year will not exceed the limits specified in part 9505.3040;

D. criteria and method used to notify and select providers;

E. proof that all services covered by the waiver will be available in the community;

F. a description of how the agency will make sure that CADI clients are applicants for admission to, or residents of, nursing homes;

G. a description of how the agency will make sure that clients are given a choice of institutional or community care according to part 9505.3025, subpart 3;

H. a description of how the agency will make sure that the safety and health of clients served by the waiver will be protected;

I. a description of how the agency will comply with the Minnesota Government Data Practices Act; and

J. a description of how the local agency will comply with subpart 4 in regard to provider records.

Subp. 2. **Resubmission of conditional approvals or rejections.** If a county plan is conditionally approved or rejected, the revised plan must be submitted within 30 days or reimbursement for CADI services will be suspended until the plan is fully approved. However, the county must continue to pay for CADI services using county funds until a county plan has been approved.

Subp. 3. **Provider agreements.** A county participating in the CADI program must designate a lead agency and must submit an enrollment form and a signed provider agreement that enrolls the lead agency as a CADI provider eligible to receive medical assistance payment for CADI services. The enrollment and signed provider agreements must be on forms provided by the commissioner.

Subp. 4. **CADI provider records.** The lead agency and a CADI provider under

contract with the lead agency must maintain complete program and fiscal records and supporting documentation identifying the CADI recipients served, the services provided, and the costs incurred. The records must be identified and maintained separately from other provider records. The lead agency's and the providers' records are subject to the maintenance schedule, audit availability requirements, and other provisions in parts 9505.1750 to 9505.2150.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3135 RATES FOR CADI SERVICES.

Subpart 1. **Notices to lead agencies.** By June 1 of each year, the commissioner shall notify a lead agency of the statewide maximum rate allowed for reimbursement of a CADI service under subpart 2.

Subp. 2. **Maximum CADI service rate.** The commissioner shall annually set the maximum rate available to a county to reimburse a provider for a CADI service other than a case management service. The rates for CADI services other than a case management service shall be adjusted for each waiver year based on medical assistance rates for equivalent services. For services that do not have a medical assistance payment rate under part 9505.0445, for years beginning on July 1 following the effective date of parts 9505.3010 to 9505.3140, the commissioner shall authorize an adjustment in the CADI rate (available to a county as reimbursement to a CADI provider) up to the percentage change forecast in the first quarter of the calendar year by the Home Health Agency Market Basket of Operating Costs, Health Care Costs. The Home Health Agency Market Basket of Operating Costs, Health Care Costs is published by Data Resources, Inc. McGraw-Hill and is subject to quarterly updating. The Home Health Agency Market Basket of Operating Costs, Health Care Costs, is incorporated by reference and is available for inspection at the department, Division of Reports and Statistics, Third Floor, 444 Lafayette Road, St. Paul, Minnesota 55101 and through the Minitex interlibrary loan system.

Subp. 3. **County CADI service rate.** A county may set rates for CADI services not to exceed the rates established in subpart 1. County rates are subject to audit by the commissioner. Administrative costs are part of the case management rate and are to be included in the case management rate and not added to the county rate for other services.

Subp. 4. **Supervision costs.** The cost of supervision for all services except extended personal care must be included in the rate unless payment for the supervision is included in the rate for skilled nursing services. Supervision of personal care services shall be paid according to the rate specified in part 9505.0445, item K, for private duty nursing performed as a supervisory visit by a private duty nurse.

Subp. 5. **Recovery of costs.** The county of service must monitor use and costs of CADI services. According to part 9505.0195, subpart 6, the county of service must pay the commissioner the amount by which the costs exceed the limits specified in part 9505.3040.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3138 CRITERION FOR DELAY IN SENDING REQUIRED NOTICES.

If information that the commissioner needs to prepare and send the notices required under parts 9505.3010 to 9505.3140 is not provided in time for the commissioner to meet the time specified in parts 9505.3010 to 9505.3140, the required notices shall be sent as soon as possible after the commissioner receives the needed information.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3139 BILLING FOR CADI SERVICES.

A provider of CADI services must submit a claim to the lead agency through the CADI recipient's case manager for payment for a CADI service specified in a CADI recipient's care plan. A claim under this part must not exceed the amount specified in the contract between the CADI provider and the lead agency that is required under part 9505.3125. The CADI provider must submit the claim for payment according to the billing procedures in part 9505.0450, however, the claim shall not be submitted directly to the department.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*

9505.3140 APPEALS.

Subpart 1. **Notice of right to appeal.** A person assessed or reassessed under part 9505.3060 has the right to appeal action described in subpart 2. The case manager must provide the person or the person's representative with written information about the right to appeal. The information must state the grounds for an appealable action and must state that CADI services will not be reduced, suspended, or terminated if the appeal is filed before the date specified in the information unless the person requests in writing not to receive CADI services while the appeal is pending.

Subp. 2. **Appealable actions.** A person being assessed or reassessed under part 9505.3060, may appeal if the following actions are taken by the agency:

A. CADI services are denied;

B. eligibility for CADI services is not determined with reasonable promptness; and

C. CADI services are reduced, suspended, or terminated.

Subp. 3. **Actions that are not appealable.** A denial, reduction, suspension, or termination of CADI services is not an appealable action if the following conditions apply:

A. the person is a nursing home resident but the cost of home care would exceed the cost of nursing home care;

B. the person is an applicant for admission to a nursing home but the costs of the CADI services exceed the limit in part 9505.3040;

C. there are no slots available for CADI services; or

D. the waiver is terminated.

Subp. 4. **Submission of appeals.** The person being assessed or reassessed who wants to appeal must submit the appeal in writing to the lead agency of the county of service or to the department within 30 days after receiving written notice of the appealable action, or within 90 days of the written notice if a good cause for delay can be shown.

Subp. 5. **Hearing of appeal.** An appeal of issues meeting the criteria under subparts 1, 2, and 4 shall be heard and decided according to Minnesota Statutes, section 256.045.

Statutory Authority: *MS s 256B.04; 256B.091; 256B.49*

History: *14 SR 2712*