

2012 DHS Policy Bill - Continuing Care Policy Provisions

Article 9 – Continuing Care Policy (All statutory references are to *Laws of Minnesota 2012, Chapter 216, SF 1675*)

Provisions that impact older adults and persons with disabilities

Consumer support grant: Updates the maximum allowable monthly Consumer Support Grant calculations to align with 2009 changes to the PCA program. *Article 9, section 9*

Vulnerable adult maltreatment, lead investigative agency: The county social service agency is designated as the lead investigative agency for reports of vulnerable adult maltreatment for licensed home and community-based services licensed beginning in 2014. The common entry point must refer maltreatment reports involving services subject to §245D to the county and notify the Department. Without this change, DHS, as the licensing entity, would be designated the lead investigative agency for reports of suspected vulnerable adult maltreatment. *Article 9, sections 31, 32*

Adult protection data management: Clarifies the authority of the commissioner to maintain a database and receive data from the lead investigative agencies on reports of suspected maltreatment of vulnerable adults. *Article 9, sections 30, 38 paragraph (c)*

Provisions that impact older adults

Older adult services community consortium demonstration project extension: The Older Adult Services Community Consortium Demonstration Projects are extended from three years to five years. The project's final report is now due January 15, 2015. The Older Adult Services Community Consortium Demonstration Projects accelerate the development of community-based services to fill gaps identified in communities by using a pool of funds and providing flexibility in the use and distribution of those funds. *Article 9, sections 33, 34*

Provisions that impact persons with disabilities

Community residential setting license: The commissioner must indicate on a foster care license whether the physical location of the foster care setting is the primary residence of the license holder. The community residential setting license is now a component of the quality outcome standards recommendations. This provides the department with the ability to better track the settings where foster care is provided for the purposes of monitoring the moratorium on corporate foster care licenses. Customized living services are excluded from quality outcome standards because they are regulated by the Department of Health. The proposed changes will allow the department to incorporate all standards that the department has jurisdiction over into the development of the Quality Outcome Standards. *Article 9, sections 3, 5, 24, 35*

Adult foster care license capacity: Extends the timeline when providers can receive an adult foster care license with a 5-bed capacity until June 30, 2014. The Department will submit amendments to the waiver programs to allow payment for services in 5-bed foster care homes. *Article 9, sections 4, 36*

Family support grant: Limits the Family Support Grant so that an individual cannot receive a Family Support Grant while using any home and community-based waiver, PCA services or Consumer Support Grant. Currently, individuals cannot access the Family Support Grant at the same time as the Developmental Disabilities waiver. *Article 9, section 6*

Biennial report: Eliminates two annual reports and one biennial report and implements a single biennial report that will provide a summary of the overarching goals and priorities of the department for individuals with disabilities, including the status of various programs. *Article 9, sections 7, 23, 25, 29*

Guardianship rule change: Eliminates the public guardianship rule that requires quarterly reports for public wards. This sets the stage for future rulemaking that will align the public guardianship reporting requirements with other case management rules and private guardianship reporting requirements. *Article 9, section 8*

Personal care assistance: Eliminates inconsistencies in PCA statute and updates statute to reflect federal waiver and state plan requirements. These changes allow DHS to fully implement 2009 and 2010 legislative changes to PCA statute. These sections also exclude the revenue generated by a qualified professional form counting toward the 72.5% PCA employee wages and benefits requirement. *Article 9, sections 11, 12*

Hourly nursing determination matrix: Requires a service provider applying for MA payments for private duty nursing to complete and submit an hourly nursing determination matrix to DHS for each service recipient. This modifies the forms the commissioner issues to providers for the purposes of collecting additional information about the authorized levels of Private Duty Nursing hours. *Article 9, section 37*

Provisions related to nursing facilities

Nursing facility bed hardships: Adds new criteria to nursing facility hardship statute on when interim and settle-up rates can be used. The nursing home moratorium law prohibits the addition of new licensed and MA certified beds, but allows a process to recognize exceptions in counties where hardship exists. *Article 9, section 1*

Obsolete nursing facility statutes: Repeals obsolete sections of statute related to nursing facilities and removes statutory references that are no longer needed due to this repeal. *Article 9, sections 2, 10, 26-28, 38 paragraphs (a) and (b)*

Article 10 – Telephone Equipment Program

Provisions related to people who are deaf, deafblind, hard of hearing

This article modernizes statute language related to telecommunications and to people with disabilities; changing, for example, “impairment” to “disability” and “telephone” to “telecommunications.” The article clarifies that the equipment provided is intended to give people with communication disabilities “functionally equivalent” access to telecommunications services. The current practice of providing devices to individuals based on assessed need is codified. The requirement for telephone companies to install outside wiring to certain households is removed. The commissioner must establish policies and

procedures for the return of equipment. Lastly, the language clarifies who may participate in the consumer protection process. *Article 10, sections 1-7*

Article 11 – Comprehensive Assessment and Case Management Reform

Provisions that impact older adults and people with disabilities

Medical service coordination (In-reach coordination): Clarifies that the intent of medical service coordination services is to connect frequent emergency room users with existing service available, rather than duplicate services. The prohibition on enrollees receiving care coordination in a health care home at the same time as in-reach coordination services is removed. *Article 11, section 1*

Personal care assistance (PCA) services: Adds medication taken by a nebulizer to the definition of self-administered medication and clarifies that a PCA can provide assistance with self-administered medication. PCAs are prohibited from determining the medication dose or time for medication for the PCA recipient. *Article 11, section 2, 3*

PCA services – Assessments: Clarifies that a long-term care consultation assessment can be conducted in place of a separate assessment for PCA services. Makes conforming changes to align PCA assessments to the new MnCHOICES assessment. Section 4 expires when the MnCHOICES assessment is operational. *Article 11, section 4, 5*

Long Term Care Consultation (LTCC): Article 11, sections 6-12 define administrative functions of assessment for program and service eligibility determination and level of care for persons who are in need of long-term care services. Changes include the following:

- An assessment now includes information about competitive employment, service eligibility determination of state plan home care services, case management, institutional level of care, and diagnostic information to determine eligibility;
- The required experience of a certified assessor is reduced from three years to two years;
- Staff designated to provide LTCC services are to be certified by timelines established by the commissioner, but no sooner than 6 months after the availability of training and certification;
- The long-term care consultation team must include public health nurses, social workers, and other professionals. Requires tribes and health plans under contract with the commissioner to provide long-term care consultation services as specified in the contract;
- The long-term care consultation assessment can be used for PCA services and private duty nursing upon statewide implementation of MnCHOICES. Requires the public health or registered nurse from the consultation team be consulted when an individual with complex health care needs is assessed;
- A lead agency certified assessor will provide assistance with transition services. The assessment for transition services should be completed within 20 calendar days from the date of the request; and
- Reimbursement for long-term care consultation services will remain the same until a new reimbursement methodology is established.

Case management redesign and study of county and tribal administrative functions: DHS must submit a report with specific recommendations and legislation by February 1, 2013 on the definitions of service

and consolidation of standards and rates for different types of case management. DHS must also evaluate county and tribal administrative functions, processes, and reimbursement methodologies for HCBS waiver administration, compliance and oversight functions and report to the legislature by February 1, 2013. *Article 11, section 42*

Provisions that impact older adults

Alternative Care case management: Changes the definition of case management under the Alternative Care Waiver so it is the same as the definition in Elderly Waiver statute. *Article 11, section 16*

Alternative Care Coordinated service and support plan: Changes the name of the “individual care plan” to “individual coordinated service and support plan”. *Article 11, section 17*

Elderly Waiver (EW) case management: Modifies the service of case management under EW, including:

- Case management services are to be provided by a public or private agency that is enrolled as a medical assistance provider and meets the proper qualifications;
- Prohibits case management services from being provided by a private agency to a recipient if the providing agency has a financial interest in the provision of any other services;
- Defines which activities are considered case management services;
- Health plans that serve individuals enrolled in prepaid medical assistance programs must provide or arrange to provide case management services. *Article 11, section 18*

EW case management – Coordinated service and support plan: Defines the contents of the coordinated service and support plan for EW clients. The contents must:

- Be developed and signed by the recipient within 10 working days after the case manager receives the assessment;
- Include the person’s need for service and how service will be met by relatives, friends, or others;
- Reasonably ensures health and safety;
- Identify the person’s preferences for services;
- Reflect informed choice;
- Identify long and short-term goals;
- Identify specific services and the amount, frequency, duration and cost of the services to be provided based on assessed needs, preferences and available resources;
- Include information about the right to appeal; and
- Include the authorized annual and estimated monthly amounts for the services.

The case manager should also include the use of volunteers, religious organizations, social clubs, and civic and service organizations to support the individual in the community. *Article 11, section 21*

Provisions that impact people with disabilities

Developmental Disabilities (DD) Waiver case management: Changes “case management administration and services” to “case management services” under the DD waiver to separate the administrative and service functions of case management. Evaluation and monitoring of services must include at least one annual face-to-face visit by the case manager. Case management services cannot be provided by a

private agency to a recipient if the providing agency has a financial interest in the provision of any other services. *Article 11, section 24*

DD, Community Alternative Care (CAC), Community Alternatives for Disabled Individuals (CADI), Brain Injury (BI) Waiver case management – Coordinated service and support plan: Changes the “individual service plan” to “coordinated service and support plan.” Each recipient of HCBS waived services must receive a copy of the coordinated service and support plan. Requires the plan to:

- Be developed and signed within 10 working days after the case manager receives the assessment from the certified assessor;
- Provide for informed choice of service and support providers and identifies all options for case management services and providers; and
- Include the authorized annual and monthly amounts for the services.

Case managers are encouraged to include the use of volunteers, religious organizations, social clubs, and civic and service organizations to support the individual in the community. *Article 11, section 25, 40*

County notification: Changes host county concurrence in the developmental disabilities waiver to county notification in all of the disability waivers. The county of financial responsibility must notify the proposed county of service if the person wishes to receive services in that county. *Article 11, section 33*

CAC, CADI, and BI Waiver case management: Makes the same changes as described in DD Waiver case management paragraph above. *Article 11, section 38, 39*

Excluded time: Eliminates personal care assistance services as an excluded time service for purposes of determining county of financial responsibility. In the event that a service recipient moves to a different county, the new county in which a recipient lives would now become the county of financial responsibility for PCA services. Before this change, the county which the recipient received PCA services before they moved would be the county of financial responsibility. *Article 11, section 41*

Article 18 – Statewide Provider Enrollment, Performance Standards, and Payment Methodology Development

Provisions that impact older adults and people with disabilities

Exclusions from licensure: Removes respite services from the list of services excluded from licensure and adds a cross-reference to §245D, the home and community-based services standards. *Article 18, section 1*

Record retention & electronic record requirements: All license holders must maintain and store records in a manner that will allow for review by the commissioner. New electronic records requirements are also created. *Article 18, sections 2-3*

Home and community-based services (HCBS); Additional standards and procedures:

- Residential and nonresidential programs for persons with disabilities or persons age 65 and older must obtain a license to provide HCBS services;

- Implementation of HCBS licensure will occur on January 1, 2014, within the limits of available appropriations or other administrative cost recovery methods;
- Applicants who do not currently hold a DHS license will receive an initial compliance monitoring visit after 12 months of the effective date of the initial license;
- Applicants who currently hold a DHS license will receive an initial compliance monitoring visit after 24 months of the effective date of the initial license; and
- DHS must consult with stakeholders to gather input related to the development of a fee. *Article 18, section 4*

§245B Changes to align with new §245D: These sections align portions of §245B licensure to language created in §245D. These sections:

- Align and create definitions for “emergency” and “incident;”
- Align license holder responsibility for consumer, service-related and protection-related rights;
- Modify environment provisions;
- Modify requirements of the license holder’s risk management plan;
- Modify staffing standards, including staff orientation requirements and the use of subcontractors;
- Align requirements for the availability of current written policies and procedures; and
- Modify requirements for the use of consumer funds. *Article 18, sections 6-15*

§245D – Home and community-based services standards: Creates §245D, HCBS Standards for currently unlicensed services funded by the Home and Community-Based Services waiver programs, including: Housing access coordination; respite services; behavioral programming; specialist services; certain companion services; personal support; 24-hour emergency assistance; night supervision; certain homemaker services; independent living skills training; prevocational services; structured day; and supported employment services.

- HCBS license holders are also subject to licensure requirements under §245A and other standards when providing services under different license(s);
- License holders are exempt from certain standards when licensed by other chapters;
- Creates service recipient and protection-related rights;
- Creates requirements and standards for the provision of health services, including medication administration and injectable medications;
- Creates protection standards for incident response and reporting, environment and safety, compliance with fire and safety codes, funds and property and prohibitions; and
- Creates standards for record requirements, staffing standards, and policies and procedures for recipient grievances, service suspension and service termination, and availability of current written policies and procedures. *Article 18, sections 16-25*

Home and community-based waivers; Providers and payment: This section makes changes to provider qualifications under all waiver programs (BI, CAC, CADI, DD, EW) and Alternative Care. It also creates new language to develop payment methodologies for home and community-based services (HCBS) under the disability waiver programs (BI, CAC, CADI, DD). (*Subdivisions 2, 3, and 4 only apply to disability services*).

Subdivision 1 requires staff that provides direct contact with service recipients to complete a background study prior to providing services, beginning July 1, 2012.

Subdivision 2 updates language from “rate-setting” to “payment.” Clarifies that counties shall not implement changes to established processes for rate-setting methodologies using data or components of or data from research rates. *Only applies to disability services.*

Subdivision 3 establishes that payment methodologies shall accommodate supervision costs, staffing patterns, program-related expenses, general and administrative expenses and consideration of recipient intensity. *Only applies to disability services.*

Subdivision 4 establishes that payment rates shall reflect the reasonable, ordinary, and necessary costs of service delivery. Payments shall be sufficient to enlist enough providers so that care is available to the extent such care and services are available to the general population. Lists the circumstances where the commissioner is prohibited from reimbursing services. *Only applies to disability services.*

Subdivision 5 eliminates county and tribal contracts with providers for HCBS waived services, per the corrective action letter from CMS, effective January 1, 2014.

Subdivision 6 gives the commissioner authority to establish program standards for home and community-based services.

Subdivision 7 requires an applicant or license holder that is not enrolled as a Minnesota health care program HCBS waiver provider at the time of application to complete a onetime training on the requirements for providing services. *Article 18, section 26*

Provisions that impact people with disabilities

Payment methodology development: Subdivision 1 establishes a research rate period and procedures for the commissioner to publish initial rate frameworks and values. The research rate values must ensure projected spending for HCBS for each service area is equivalent to projected spending under current law in the most recent forecast. Requires initial values to be based on the most updated information and cost data available on supervision, employee-related costs, client programming and supports, programming planning supports, transportation, administrative overhead, and utilization costs. Establishes five service areas. Requires the commissioner to make available the underlying assessment information.

Subdivision 2 requires the commissioner to propose legislation with the specific payment methodology frameworks, process for calculation, and specific values to populate the frameworks by February 15, 2013, including a legislative report. Requires the commissioner to provide the underlying data and information used to formulate the frameworks and values to the existing stakeholder list. Specifies the elements to be researched.

Subdivision 3 requires the commissioner to complete research and gather additional data for the further development and refinement of payment methodology components and provide this information to the existing workgroup by January 15, 2013.

Subdivision 4 requires the commissioner to adjust rates determined by the new payment methodology so that the new rate varies by no more than one percent per year from the rate effective December 31 of the prior calendar year. This adjustment is made annually for three calendar years from the date of implementation.

Subdivision 5 requires the commissioner to continue consultation on regular intervals with the existing stakeholder workgroup established as part of the rate-setting methodology process to gather input, concerns, data, and exchange ideas for the legislative proposals. Requires the commissioner to make this information available through the Department's website.

Subdivision 6 allows the commissioner to implement rate changes no sooner than January 1, 2014 to payment rates for individuals receiving HCBS waived services after the enactment of legislation that establishes specific payment methodology frameworks, processes and values to populate the frameworks. *Article 18, section 27*

Minnesota Laws 2012, Chapter 271 (SF1679)

Traumatic Brain Injury Advisory Council: This section extends the Traumatic Brain Injury Advisory Committee from expiring on June 30, 2012, to June 30, 2014. *Laws of Minnesota, 2012, Chapter 271, section 3*

List of acronyms

AC – Alternative Care
BI – Brain Injury
CAC – Community Alternative Care
CADI – Community Alternatives for Disabled Individuals
CMS – Centers for Medicare and Medicaid Services
DD – Developmental Disabilities
DHS – Department of Human Services
EW – Elderly Waiver
HCBS – Home and Community-Based Services
LTCC – Long-term Care Consultation
MA – Medical Assistance
PCA – Personal Care Assistance