(g) establish criteria to be used in determining individual eligibility for special transportation services;

(h) consult with the transportation accessibility advisory committee in a timely manner before changes are made in the provision of special transportation services, including, but not limited to, changes in policies affecting the matters subject to hearing under subdivision 2;

(i) provide for effective administration and enforcement of board policies and standards; and

(j) annually evaluate providers of special transportation service to ensure compliance with the standards established for the program.

Sec. 3. **APPLICATION.**

This act applies to the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington.

Presented to the governor March 31, 1992

Signed by the governor April 2, 1992, 2:17 p.m.

CHAPTER 391—S.F.No. 2337

An act relating to human services; providing for medical assistance coverage of home health services delivered in a facility under certain circumstances; providing for medical assistance coverage of personal care services provided outside the home when authorized by the responsible party; allowing foster care providers to deliver personal care services if monitored; defining responsible party; allowing recipients to request continuation of services at a previously authorized level while an appeal is pending; requiring cost effectiveness of services to be considered; amending Minnesota Statutes 1991 Supplement, sections 256B.0625, subdivisions 6a and 19a; and 256B.0627, subdivisions 1, 4, 5, and 6.

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

Section 1. Minnesota Statutes 1991 Supplement, section 256B.0625, subdivision 6a, is amended to read:

Subd. 6a. **HOME HEALTH SERVICES.** Home health services are those services specified in Minnesota Rules, part 9505.0290. Medical assistance covers home health services at a recipient's home residence. Medical assistance does not cover home health services at a hospital, nursing facility, intermediate care facility, or a health care facility licensed by the commissioner of health, unless the program is funded under a home- and community-based services waiver or unless the commissioner of human services has prior authorized skilled nurse visits for less than 90 days for a resident at an intermediate care facility for per-

sons with mental retardation, to prevent an admission to a hospital or nursing facility. Home health services must be provided by a Medicare certified home health agency. All nursing and home health aide services must be provided according to section 256B.0627.

Sec. 2. Minnesota Statutes 1991 Supplement, section 256B.0625, subdivision 19a, is amended to read:

Subd. 19a. **PERSONAL CARE SERVICES.** Medical assistance covers personal care services in a recipient's home. Recipients who can direct their own care, or persons who cannot direct their own care when ~~accompanied~~ authorized by the responsible party, may use approved hours outside the home when normal life activities take them outside the home and when, without the provision of personal care, their health and safety would be jeopardized. Medical assistance does not cover personal care services at a hospital, nursing facility, intermediate care facility or a health care facility licensed by the commissioner of health, except as authorized in section 256B.64 for ventilator-dependent recipients in hospitals. Total hours of service and payment allowed for services outside the home cannot exceed that which is otherwise allowed for personal care services in an in-home setting according to section 256B.0627. All personal care services must be provided according to section 256B.0627. Personal care services may not be reimbursed if the personal care assistant is the spouse of the recipient or the parent of a recipient under age 18, the responsible party~~,~~ or the foster care provider of a recipient who cannot direct ~~their~~ the recipient's own care or the recipient's legal guardian unless, in the case of a foster provider, a county or state case manager visits the recipient as needed, but no less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met. Parents of adult recipients, adult children of the recipient or adult siblings of the recipient may be reimbursed for personal care services if they are granted a waiver under section 256B.0627. ~~An exception for foster care providers may be made according to section 256B.0627, subdivision 5, paragraph (j).~~

Sec. 3. Minnesota Statutes 1991 Supplement, section 256B.0627, subdivision 1, is amended to read:

Subdivision 1. **DEFINITION.** (a) "Home care services" means a health service, determined by the commissioner as medically necessary, that is ordered by a physician and documented in a care plan that is reviewed by the physician at least once every 60 days for the provision of home health services, or private duty nursing, or at least once every 365 days for personal care. Home care services are provided to the recipient at the recipient's residence that is a place other than a hospital or long-term care facility or as specified in section 256B.0625.

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

(c) "Care plan" means a written description of the services needed which

~~shall include~~ is signed by the recipient or responsible party and includes a detailed description of the covered home care services, who is providing the services, frequency ~~of those services,~~ and duration of ~~those~~ services. ~~The care plan shall also include,~~ and expected outcomes and goals including expected date of goal accomplishment.

(d) "Responsible party" means an individual residing with a recipient of personal care services who is capable of providing the supportive care necessary to assist the recipient to live in the community, is at least 18 years old, and is not a personal care assistant. Responsible parties who are parents of minors or guardians of minors or incapacitated persons may delegate the responsibility to another adult during a temporary absence of at least 24 hours but not more than six months. The person delegated as a responsible party must be able to meet the definition of responsible party, except that the delegated responsible party is required to reside with the recipient only while serving as the responsible party. Foster care license holders may be designated the responsible party for residents of the foster care home if case management is provided as required in section 256B.0625, subdivision 19a. For persons who, as of April 1, 1992, are sharing personal care services in order to obtain the availability of 24-hour coverage, an employee of the personal care provider organization may be designated as the responsible party if case management is provided as required in section 256B.0625, subdivision 19a.

Sec. 4. Minnesota Statutes 1991 Supplement, section 256B.0627, subdivision 4, is amended to read:

Subd. 4. **PERSONAL CARE SERVICES.** (a) The personal care services that are eligible for payment are the following:

(1) bowel and bladder care;

(2) skin care to maintain the health of the skin;

(3) range of motion exercises;

(4) respiratory assistance;

(5) transfers;

(6) bathing, grooming, and hairwashing necessary for personal hygiene;

(7) turning and positioning;

(8) assistance with furnishing medication that is normally self-administered;

(9) application and maintenance of prosthetics and orthotics;

(10) cleaning medical equipment;

(11) dressing or undressing;

(12) assistance with food, nutrition, and diet activities;

(13) accompanying a recipient to obtain medical diagnosis or treatment;

(14) helping the recipient to complete daily living skills such as personal and oral hygiene and medication schedules;

(15) supervision and observation that are medically necessary because of the recipient's diagnosis or disability; and

(16) incidental household services that are an integral part of a personal care service described in clauses (1) to (15).

(b) The personal care services that are not eligible for payment are the following:

(1) personal care services that are not in the care plan developed by the supervising registered nurse in consultation with the personal care assistants and the recipient or the responsible party directing the care of the recipient;

(2) services that are not supervised by the registered nurse;

(3) services provided by the recipient's spouse, legal guardian, or parent of a minor child;

(4) services provided by a foster care provider of a recipient who cannot direct their own care, unless ~~prior authorized by the commissioner under paragraph (j)~~ monitored by a county or state case manager under section 256B.0625, subdivision 19a;

(5) sterile procedures;

(6) injections of fluids into veins, muscles, or skin;

(7) services provided by parents of adult recipients, adult children, or ~~adult~~ siblings, unless these relatives meet one of the following hardship criteria and the commissioner waives this requirement:

(i) the relative resigns from a part-time or full-time job to provide personal care for the recipient;

(ii) the relative goes from a full-time to a part-time job with less compensation to provide personal care for the recipient;

(iii) the relative takes a leave of absence without pay to provide personal care for the recipient;

(iv) the relative incurs substantial expenses by providing personal care for the recipient; or

(v) because of labor conditions, the relative is needed in order to provide an

adequate number of qualified personal care assistants to meet the medical needs of the recipient;

(8) homemaker services that are not an integral part of a personal care services; and

(9) home maintenance, or chore services.

Sec. 5. Minnesota Statutes 1991 Supplement, section 256B.0627, subdivision 5, is amended to read:

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

(a) **EXEMPTION FROM PAYMENT LIMITATIONS.** The level, or the number of hours or visits of a specific service, of home care services to a recipient that began before and is continued without increase on or after December 1987, shall be exempt from the payment limitations of this section, as long as the services are medically necessary.

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

(1) a total of 40 home health aide visits, skilled nurse visits, health promotions, or health assessments under section 256B.0625, subdivision 6a; and

(2) a total of ten hours of nursing supervision under section 256B.0625, subdivision 7 or 19a.

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

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

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

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

(d) **RETROACTIVE AUTHORIZATION.** A request for retroactive authorization under paragraph (c) will be evaluated according to the same criteria applied to prior authorization requests. Implementation of this provision shall begin no later than October 1, 1991, except that recipients who are currently receiving medically necessary services above the limits established under this subdivision may have a reasonable amount of time to arrange for waivered services under section 256B.49 or to establish an alternative living arrangement. All current recipients shall be phased down to the limits established under paragraph (b) on or before April 1, 1992.

(e) **ASSESSMENT AND CARE PLAN.** The home care provider shall conduct an assessment and complete a care plan using forms specified by the commissioner. For the recipient to receive, or continue to receive, home care services, the provider must submit evidence necessary for the commissioner to determine the medical necessity of the home care services. The provider shall submit to the commissioner the assessment, the care plan, and other information necessary to determine medical necessity such as diagnostic or testing information, social or medical histories, and hospital or facility discharge summaries.

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

(1) **HOME HEALTH SERVICES.** All home health services provided by a nurse or a home health aide that exceed the limits established in paragraph (b) must be prior authorized by the commissioner or the commissioner's designee. Prior authorization must be based on medical necessity and cost-effectiveness when compared with other care options. When home health services are used in combination with personal care and private duty nursing, the cost of all home care services shall be considered for cost effectiveness.

(2) **PERSONAL CARE SERVICES.** (i) All personal care services must be prior authorized by the commissioner or the commissioner's designee except for the limits on supervision established in paragraph (b). The amount of personal care services authorized must be based on the recipient's case mix classification according to section 256B.0911, except that a child may not be found to be dependent in an activity of daily living if because of the child's age an adult would either perform the activity for the child or assist the child with the activity and the amount of assistance needed is similar to the assistance appropriate for a typical child of the same age. Based on medical necessity, the commissioner may authorize:

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

(B) up to three times the average number of direct care hours provided in nursing facilities for recipients who have complex medical needs;

(C) up to 60 percent of the average reimbursement rate, as of July 1, 1991, for care provided in a regional treatment center for recipients who have complex behaviors;

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

(E) up to the amount medical assistance would reimburse for facility care for recipients referred to the commissioner by a preadmission screening team established under section 256B.091 or 256B.092.

(ii) The number of direct care hours shall be determined according to annual cost reports which are submitted to the department by nursing facilities each year. The average number of direct care hours, as established by May 1, shall be incorporated into the home care limits on July 1 each year.

(iii) The case mix level shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner by the personal care provider on forms specified by the commissioner. The forms shall be a combination of current assessment tools developed under sections 256B.0911 and 256B.501 with an addition for seizure activity that will assess the frequency and severity of seizure activity and with adjustments, additions, and clarifications that are necessary to reflect the needs and conditions of children and nonelderly adults who need home care. The commissioner shall establish these forms and protocols under this section and shall use the advisory group established in section 256B.04, subdivision 16, for consultation in establishing the forms and protocols by October 1, 1991.

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

(A) daily tube feedings;

(B) daily parenteral therapy;

(C) wound or decubiti care;

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

(E) catheterization;

(F) ostomy care; ~~or~~

(G) quadriplegia; or

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

(v) A recipient shall qualify as having complex behavior if the recipient exhibits on a daily basis the following:

(A) self-injurious behavior;

(B) unusual or repetitive habits;

(C) withdrawal behavior;

(D) hurtful behavior to others;

(E) socially or offensive behavior;

(F) destruction of property; or

(G) a need for constant one-to-one supervision for self-preservation.

(vi) The complex behaviors in clauses (A) to (G) have the meanings developed under section 256B.501.

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

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

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

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

(4) **VENTILATOR-DEPENDENT RECIPIENTS.** If the recipient is ventilator-dependent, the monthly medical assistance authorization for home care services shall not exceed what the commissioner would pay for care at the high-

est cost hospital designated as a long-term hospital under the Medicare program. For purposes of this clause, home care services means all services provided in the home that would be included in the payment for care at the long-term hospital. "Ventilator-dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent for at least 30 consecutive days.

(g) **PRIOR AUTHORIZATION; TIME LIMITS.** The commissioner or the commissioner's designee shall determine the time period for which a prior authorization shall remain valid. If the recipient continues to require home care services beyond the duration of the prior authorization, the home care provider must request a new prior authorization through the process described above. Under no circumstances shall a prior authorization be valid for more than 12 months. A recipient who appeals a reduction in previously authorized home care services may request that the previously authorized services, other than temporary services under paragraph (i), be continued pending an appeal under section 256.045, subdivision 10.

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

(i) **PRIOR AUTHORIZATION REQUESTS; TEMPORARY SERVICES.** ~~The department has 30 days from receipt of the request to complete the prior authorization, during which time it may approve a temporary level of home care service. Authorization under this authority for a temporary level of home care services is limited to the time specified by the commissioner.~~ Providers may request a temporary authorization for home care services by telephone. The commissioner may approve a temporary level of home care services based on the assessment and care plan information provided by an appropriately licensed nurse. Authorization for a temporary level of home care services is limited to the time specified by the commissioner, but shall not exceed 30 days. The level of services authorized under this provision shall have no bearing on a future prior authorization.

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

The commissioner may not authorize:

(1) home care services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules;

(2) personal care services when the foster care license holder is also the personal care provider or personal care assistant unless the recipient can direct the recipient's own care, or ~~the recipient is referred to the commissioner by a~~ case management is provided as required in section 256B.0625, subdivision 19a ~~regional treatment center preadmission evaluation team~~;

(3) personal care services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care assistant, unless ~~the recipient is referred to the commissioner by a regional treatment center preadmission evaluation team~~ case management is provided as required in section 256B.0625, subdivision 19a;

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

(5) home care services when combined with foster care payments, ~~less the base rate~~ other than room and board payments plus the cost of home- and community-based waivered services unless the costs of home care services and waivered services are combined and managed under the waiver program, that exceed the total amount that public funds would pay for the recipient's care in a medical institution.

Sec. 6. Minnesota Statutes 1991 Supplement, section 256B.0627, subdivision 6, is amended to read:

Subd. 6. **RECOVERY OF EXCESSIVE PAYMENTS.** The commissioner shall seek monetary recovery from providers of payments made for services which exceed the limits established in this section. This subdivision does not apply to services provided to a recipient at the previously authorized level pending an appeal under section 256.045, subdivision 10.

Sec. 7. **EFFECTIVE DATE.**

Sections 1 to 6 are effective the day following final enactment.

Presented to the governor March 31, 1992

Signed by the governor March 31, 1992, 5:58 p.m.