256B.0657 SELF-DIRECTED SUPPORTS OPTION.

Subdivision 1. **Definition.** "Self-directed supports option" means personal assistance, supports, items, and related services purchased under an approved budget plan and budget by a recipient.

[See Note.]

Subd. 2. **Eligibility.** (a) The self-directed supports option is available to a person who:

(1) is a recipient of medical assistance as determined under sections 256B.055, 256B.056, and 256B.057, subdivision 9;

(2) is eligible for personal care assistance services under section 256B.0659;

(3) lives in the person's own apartment or home, which is not owned, operated, or controlled by a provider of services not related by blood or marriage;

(4) has the ability to hire, fire, supervise, establish staff compensation for, and manage the individuals providing services, and to choose and obtain items, related services, and supports as described in the participant's plan. If the recipient is not able to carry out these functions but has a legal guardian or parent to carry them out, the guardian or parent may fulfill these functions on behalf of the recipient; and

(5) has not been excluded or disenrolled by the commissioner.

(b) The commissioner may disenroll or exclude recipients, including guardians and parents, under the following circumstances:

(1) recipients who have been restricted by the Primary Care Utilization Review Committee may be excluded for a specified time period;

(2) recipients who exit the self-directed supports option during the recipient's service plan year shall not access the self-directed supports option for the remainder of that service plan year; and

(3) when the department determines that the recipient cannot manage recipient responsibilities under the program.

[See Note.]

Subd. 3. **Eligibility for other services.** Selection of the self-directed supports option by a recipient shall not restrict access to other medically necessary care and services furnished under the state plan medical assistance benefit, including home care targeted case management, except that a person receiving home and community-based waiver services, a family support grant, or a consumer support grant is not eligible for funding under the self-directed supports option.

[See Note.]

Subd. 4. **Assessment requirements.** (a) The self-directed supports option assessment must meet the following requirements:

(1) it shall be conducted by the county public health nurse or a certified public health nurse under contract with the county;

(2) it shall be conducted face-to-face in the recipient's home initially, and at least annually thereafter; when there is a significant change in the recipient's condition; and when there is a change in the need for personal care assistance services. A recipient who is residing in a facility may be assessed for the self-directed support option for the purpose of returning to the community using this option; and

(3) it shall be completed using the format established by the commissioner.

(b) The results of the assessment and recommendations shall be communicated to the commissioner and the recipient by the county public health nurse or certified public health nurse under contract with the county.

[See Note.]

Subd. 5. **Self-directed supports option plan requirements.** (a) The plan for the self-directed supports option must meet the following requirements:

(1) the plan must be completed using a person-centered process that:

(i) builds upon the recipient's capacity to engage in activities that promote community life;

(ii) respects the recipient's preferences, choices, and abilities;

(iii) involves families, friends, and professionals in the planning or delivery of services or supports as desired or required by the recipient; and

(iv) addresses the need for personal care assistance services identified in the recipient's self-directed supports option assessment;

(2) the plan shall be developed by the recipient or by the guardian of an adult recipient or by a parent or guardian of a minor child, and may be assisted by a provider who meets the requirements established for using a person-centered planning process and shall be reviewed at least annually upon reassessment or when there is a significant change in the recipient's condition; and

(3) the plan must include the total budget amount available divided into monthly amounts that cover the number of months of personal care assistance services authorization included in the budget. The amount used each month may vary, but additional funds shall not be provided above the annual personal care assistance services authorized amount unless a change in condition is documented.

(b) The commissioner shall:

(1) establish the format and criteria for the plan as well as the requirements for providers who assist with plan development;

(2) review the assessment and plan and, within 30 days after receiving the assessment and plan, make a decision on approval of the plan;

(3) notify the recipient, parent, or guardian of approval or denial of the plan and provide notice of the right to appeal under section 256.045; and

(4) provide a copy of the plan to the fiscal support entity selected by the recipient.

[See Note.]

Subd. 6. **Services covered.** (a) Services covered under the self-directed supports option include:

(1) personal care assistance services under section 256B.0659; and

(2) items, related services, and supports, including assistive technology, that increase independence or substitute for human assistance to the extent expenditures would otherwise be used for human assistance.

(b) Items, supports, and related services purchased under this option shall not be considered home care services for the purposes of section 144A.43.

[See Note.]

Subd. 7. **Noncovered services.** Services or supports that are not eligible for payment under the self-directed supports option include:

(1) services, goods, or supports that do not benefit the recipient;

(2) any fees incurred by the recipient, such as Minnesota health care program fees and co-pays, legal fees, or costs related to advocate agencies;

(3) insurance, except for insurance costs related to employee coverage or fiscal support entity payments;

(4) room and board and personal items that are not related to the disability, except that medically prescribed specialized diet items may be covered if they reduce the need for human assistance;

(5) home modifications that add square footage;

(6) home modifications for a residence other than the primary residence of the recipient, or in the event of a minor with parents not living together, the primary residences of the parents;

(7) expenses for travel, lodging, or meals related to training the recipient, the parent or guardian of an adult recipient, or the parent or guardian of a minor child, or paid or unpaid caregivers that exceed $500 in a 12-month period;

(8) experimental treatment;

(9) any service or item covered by other medical assistance state plan services, including prescription and over-the-counter medications, compounds, and solutions and related fees, including premiums and co-payments;

(10) membership dues or costs, except when the service is necessary and appropriate to treat a physical condition or to improve or maintain the recipient's physical condition. The condition must be identified in the recipient's plan of care and monitored by a Minnesota health care program enrolled physician;

(11) vacation expenses other than the cost of direct services;

(12) vehicle maintenance or modifications not related to the disability;

(13) tickets and related costs to attend sporting or other recreational events; and

(14) costs related to Internet access, except when necessary for operation of assistive technology, to increase independence, or to substitute for human assistance.

[See Note.]

Subd. 8. **Self-directed budget requirements.** The budget for the provision of the self-directed service option shall be established based on:

(1) assessed personal care assistance units, not to exceed the maximum number of personal care assistance units available, as determined by section 256B.0659; and

(2) the personal care assistance unit rate:

(i) with a reduction to the unit rate to pay for a program administrator as defined in subdivision 10; and

(ii) an additional adjustment to the unit rate as needed to ensure cost neutrality for the state.

[See Note.]

Subd. 9. **Quality assurance and risk management.** (a) The commissioner shall establish quality assurance and risk management measures for use in developing and implementing self-directed plans and budgets that (1) recognize the roles and responsibilities involved in obtaining services in a self-directed manner, and (2) assure the appropriateness of such plans and budgets based upon a recipient's resources and capabilities. These measures must include (i) background studies, and (ii) backup and emergency plans, including disaster planning.

(b) The commissioner shall provide ongoing technical assistance and resource and educational materials for families and recipients selecting the self-directed option.

(c) Performance assessments measures, such as of a recipient's satisfaction with the services and supports, and ongoing monitoring of health and well-being shall be identified in consultation with the stakeholder group.

[See Note.]

Subd. 10. **Fiscal support entity.** (a) Each recipient shall choose a fiscal support entity provider certified by the commissioner to make payments for services, items, supports, and administrative costs related to managing a self-directed service plan authorized for payment in the approved plan and budget. Recipients shall also choose the payroll, agency with choice, or the fiscal conduit model of financial and service management.

(b) The fiscal support entity:

(1) may not limit or restrict the recipient's choice of service or support providers, including use of the payroll, agency with choice, or fiscal conduit model of financial and service management;

(2) must have a written agreement with the recipient or the recipient's representative that identifies the duties and responsibilities to be performed and the specific related charges;

(3) must provide the recipient and the home care targeted case manager with a monthly written summary of the self-directed supports option services that were billed, including charges from the fiscal support entity;

(4) must be knowledgeable of and comply with Internal Revenue Service requirements necessary to process employer and employee deductions, provide appropriate and timely submission of employer tax liabilities, and maintain documentation to support medical assistance claims;

(5) must have current and adequate liability insurance and bonding and sufficient cash flow and have on staff or under contract a certified public accountant or an individual with a baccalaureate degree in accounting; and

(6) must maintain records to track all self-directed supports option services expenditures, including time records of persons paid to provide supports and receipts for any goods purchased. The records must be maintained for a minimum of five years from the claim date and be available for audit or review upon request. Claims submitted by the fiscal support entity must correspond with services, amounts, and time periods as authorized in the recipient's self-directed supports option plan.

(c) The commissioner shall have authority to:

(1) set or negotiate rates with fiscal support entities;

(2) limit the number of fiscal support entities;

(3) identify a process to certify and recertify fiscal support entities and assure fiscal support entities are available to recipients throughout the state; and

(4) establish a uniform format and protocol to be used by eligible fiscal support entities.

[See Note.]

Subd. 11. **Stakeholder consultation.** The commissioner shall consult with a statewide consumer-directed services stakeholder group, including representatives of all types of consumer-directed service users, advocacy organizations, counties, and consumer-directed service providers. The commissioner shall seek recommendations from this stakeholder group in developing:

(1) the self-directed plan format;

(2) requirements and guidelines for the person-centered plan assessment and planning process;

(3) implementation of the option and the quality assurance and risk management techniques; and

(4) standards and requirements, including rates for the personal support plan development provider and the fiscal support entity; policies; training; and implementation. The stakeholder group shall provide recommendations on the repeal of the personal care assistance choice option, transition issues, and whether the consumer support grant program under section 256.476 should be modified. The stakeholder group shall meet at least three times each year to provide advice on policy, implementation, and other aspects of consumer and self-directed services.

Subd. 12. **Enrollment and evaluation.** Enrollment in the self-directed supports option is available to current personal care assistance recipients upon annual personal care assistance reassessment, with a maximum enrollment of 1,000 people in the first fiscal year of implementation and an additional 1,000 people in the second fiscal year. The commissioner shall

evaluate the self-directed supports option during the first two years of implementation and make any necessary changes prior to the option becoming available statewide.

History: *2007 c 147 art 7 s 12; 2009 c 79 art 6 s 10-12; art 8 s 29,30,85; 2009 c 159 s 90*

NOTE: Subdivisions 1 to 10 as added by Laws 2007, chapter 147, article 7, section 12, are effective upon federal approval of the state Medicaid plan amendment. Laws 2007, chapter 147, article 7, section 12, the effective date.