

**256B.49 HOME AND COMMUNITY-BASED SERVICE WAIVERS FOR DISABLED.**

Subdivision 1. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 2. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 3. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 4. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 5. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 6. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 7. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 8. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 9. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 10. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 11. **Authority.** (a) The commissioner is authorized to apply for home and community-based service waivers, as authorized under section 1915(c) of the Social Security Act to serve persons under the age of 65 who are determined to require the level of care provided in a nursing home and persons who require the level of care provided in a hospital. The commissioner shall apply for the home and community-based waivers in order to:

- (i) promote the support of persons with disabilities in the most integrated settings;
- (ii) expand the availability of services for persons who are eligible for medical assistance;
- (iii) promote cost-effective options to institutional care; and
- (iv) obtain federal financial participation.

(b) The provision of waived services to medical assistance recipients with disabilities shall comply with the requirements outlined in the federally approved applications for home and community-based services and subsequent amendments, including provision of services according to a service plan designed to meet the needs of the individual. For purposes of this section, the approved home and community-based application is considered the necessary federal requirement.

(c) The commissioner shall provide interested persons serving on agency advisory committees, task forces, the Centers for Independent Living, and others who request to be on a list to receive, notice of, and an opportunity to comment on, at least 30 days before any effective dates, (1) any substantive changes to the state's disability services program manual, or (2) changes or amendments to the federally approved applications for home and community-based waivers, prior to their submission to the federal Centers for Medicare and Medicaid Services.

(d) The commissioner shall seek approval, as authorized under section 1915(c) of the Social Security Act, to allow medical assistance eligibility under this section for children under age 21 without deeming of parental income or assets.

(e) The commissioner shall seek approval, as authorized under section 1915(c) of the Social Act, to allow medical assistance eligibility under this section for individuals under age 65 without deeming the spouse's income or assets.

Subd. 11a. **Waivered services statewide priorities.** (a) The commissioner shall establish statewide priorities for individuals on the waiting list for community alternative care, community alternatives for disabled individuals, and brain injury waiver services, as of January 1, 2010. The

statewide priorities must include, but are not limited to, individuals who continue to have a need for waiver services after they have maximized the use of state plan services and other funding resources, including natural supports, prior to accessing waiver services, and who meet at least one of the following criteria:

- (1) have unstable living situations due to the age, incapacity, or sudden loss of the primary caregivers;
- (2) are moving from an institution due to bed closures;
- (3) experience a sudden closure of their current living arrangement;
- (4) require protection from confirmed abuse, neglect, or exploitation;
- (5) experience a sudden change in need that can no longer be met through state plan services or other funding resources alone; or
- (6) meet other priorities established by the department.

(b) When allocating resources to lead agencies, the commissioner must take into consideration the number of individuals waiting who meet statewide priorities and the lead agencies' current use of waiver funds and existing service options.

(c) The commissioner shall evaluate the impact of the use of statewide priorities and provide recommendations to the legislature on whether to continue the use of statewide priorities in the November 1, 2011, annual report required by the commissioner in sections 256B.0916, subdivision 7, and 256B.49, subdivision 21.

**Subd. 12. Informed choice.** Persons who are determined likely to require the level of care provided in a nursing facility as determined under section 256B.0911 or a hospital shall be informed of the home and community-based support alternatives to the provision of inpatient hospital services or nursing facility services. Each person must be given the choice of either institutional or home and community-based services using the provisions described in section 256B.77, subdivision 2, paragraph (p).

**Subd. 13. Case management.** (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application. The case management service activities provided must include:

- (1) finalizing the written coordinated service and support plan within ten working days after the case manager receives the plan from the certified assessor;
- (2) informing the recipient or the recipient's legal guardian or conservator of service options;
- (3) assisting the recipient in the identification of potential service providers and available options for case management service and providers;
- (4) assisting the recipient to access services and assisting with appeals under section 256.045; and
- (5) coordinating, evaluating, and monitoring of the services identified in the service plan.

(b) The case manager may delegate certain aspects of the case management service activities to another individual provided there is oversight by the case manager. The case manager may not delegate those aspects which require professional judgment including:

- (1) finalizing the coordinated service and support plan;

(2) ongoing assessment and monitoring of the person's needs and adequacy of the approved coordinated service and support plan; and

(3) adjustments to the coordinated service and support plan.

(c) Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has any financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

**Subd. 14. Assessment and reassessment.** (a) Assessments and reassessments shall be conducted by certified assessors according to section 256B.0911, subdivision 2b. With the permission of the recipient or the recipient's designated legal representative, the recipient's current provider of services may submit a written report outlining their recommendations regarding the recipient's care needs prepared by a direct service employee with at least 20 hours of service to that client. The person conducting the assessment or reassessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment and the person or the person's legal representative and must be considered prior to the finalization of the assessment or reassessment.

(b) There must be a determination that the client requires a hospital level of care or a nursing facility level of care as defined in section 256B.0911, subdivision 4a, paragraph (d), at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(c) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only face-to-face assessments conducted according to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care determination or a nursing facility level of care determination must be accepted for purposes of initial and ongoing access to waiver services payment.

(d) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

(e) The commissioner shall develop criteria to identify recipients whose level of functioning is reasonably expected to improve and reassess these recipients to establish a baseline assessment. Recipients who meet these criteria must have a comprehensive transitional service plan developed under subdivision 15, paragraphs (b) and (c), and be reassessed every six months until there has been no significant change in the recipient's functioning for at least 12 months. After there has been no significant change in the recipient's functioning for at least 12 months, reassessments of the recipient's strengths, informal support systems, and need for services shall be conducted at least every 12 months and at other times when there has been a significant change in the recipient's functioning. Counties, case managers, and service providers are responsible for conducting these reassessments and shall complete the reassessments out of existing funds.

*[See Note.]*

**Subd. 15. Coordinated service and support plan; comprehensive transitional service plan; maintenance service plan.** (a) Each recipient of home and community-based waived services shall be provided a copy of the written coordinated service and support plan which meets the requirements in section 256B.092, subdivision 1b.

(b) In developing the comprehensive transitional service plan, the individual receiving services, the case manager, and the guardian, if applicable, will identify the transitional service plan fundamental service outcome and anticipated timeline to achieve this outcome. Within the first 20 days following a recipient's request for an assessment or reassessment, the transitional service planning team must be identified. A team leader must be identified who will be responsible for assigning responsibility and communicating with team members to ensure implementation of the transition plan and ongoing assessment and communication process. The team leader should be an individual, such as the case manager or guardian, who has the opportunity to follow the recipient to the next level of service.

Within ten days following an assessment, a comprehensive transitional service plan must be developed incorporating elements of a comprehensive functional assessment and including short-term measurable outcomes and timelines for achievement of and reporting on these outcomes. Functional milestones must also be identified and reported according to the timelines agreed upon by the transitional service planning team. In addition, the comprehensive transitional service plan must identify additional supports that may assist in the achievement of the fundamental service outcome such as the development of greater natural community support, increased collaboration among agencies, and technological supports.

The timelines for reporting on functional milestones will prompt a reassessment of services provided, the units of services, rates, and appropriate service providers. It is the responsibility of the transitional service planning team leader to review functional milestone reporting to determine if the milestones are consistent with observable skills and that milestone achievement prompts any needed changes to the comprehensive transitional service plan.

For those whose fundamental transitional service outcome involves the need to procure housing, a plan for the recipient to seek the resources necessary to secure the least restrictive housing possible should be incorporated into the plan, including employment and public supports such as housing access and shelter needy funding.

(c) Counties and other agencies responsible for funding community placement and ongoing community supportive services are responsible for the implementation of the comprehensive transitional service plans. Oversight responsibilities include both ensuring effective transitional service delivery and efficient utilization of funding resources.

(d) Following one year of transitional services, the transitional services planning team will make a determination as to whether or not the individual receiving services requires the current level of continuous and consistent support in order to maintain the recipient's current level of functioning. Recipients who are determined to have not had a significant change in functioning for 12 months must move from a transitional to a maintenance service plan. Recipients on a maintenance service plan must be reassessed to determine if the recipient would benefit from a transitional service plan at least every 12 months and at other times when there has been a significant change in the recipient's functioning. This assessment should consider any changes to technological or natural community supports.

(e) When a county is evaluating denials, reductions, or terminations of home and community-based services under section 256B.49 for an individual, the case manager shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the coordinated service and support plan, comprehensive transitional service plan, or maintenance service plan. The reduction in the authorized services for an individual due to changes in funding for waived services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

(f) At the time of reassessment, local agency case managers shall assess each recipient of community alternatives for disabled individuals or brain injury waived services currently residing in a licensed adult foster home that is not the primary residence of the license holder, or in which the license holder is not the primary caregiver, to determine if that recipient could appropriately be served in a community-living setting. If appropriate for the recipient, the case manager shall offer the recipient, through a person-centered planning process, the option to receive alternative housing and service options. In the event that the recipient chooses to transfer from the adult foster home, the vacated bed shall not be filled with another recipient of waiver services and group residential housing and the licensed capacity shall be reduced accordingly, unless the savings required by the licensed bed closure reductions under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), for foster care settings where the physical location is not the primary residence of the license holder are met through voluntary changes described in section 245A.03, subdivision 7, paragraph (f), or as provided under paragraph (a), clauses (3) and (4). If the adult foster home becomes no longer viable due to these transfers, the county agency, with the assistance of the department, shall facilitate a consolidation of settings or closure. This reassessment process shall be completed by July 1, 2013.

*[See Note.]*

Subd. 16. **Services and supports.** (a) Services and supports included in the home and community-based waivers for persons with disabilities shall meet the requirements set out in United States Code, title 42, section 1396n. The services and supports, which are offered as alternatives to institutional care, shall promote consumer choice, community inclusion, self-sufficiency, and self-determination.

(b) Beginning January 1, 2003, the commissioner shall simplify and improve access to home and community-based waived services, to the extent possible, through the establishment of a common service menu that is available to eligible recipients regardless of age, disability type, or waiver program.

(c) Consumer directed community support services shall be offered as an option to all persons eligible for services under subdivision 11, by January 1, 2002.

(d) Services and supports shall be arranged and provided consistent with individualized written plans of care for eligible waiver recipients.

(e) A transitional supports allowance shall be available to all persons under a home and community-based waiver who are moving from a licensed setting to a community setting. "Transitional supports allowance" means a onetime payment of up to \$3,000, to cover the costs, not covered by other sources, associated with moving from a licensed setting to a community setting. Covered costs include:

(1) lease or rent deposits;

- (2) security deposits;
- (3) utilities setup costs, including telephone;
- (4) essential furnishings and supplies; and
- (5) personal supports and transports needed to locate and transition to community settings.

(f) The state of Minnesota and county agencies that administer home and community-based waived services for persons with disabilities, shall not be liable for damages, injuries, or liabilities sustained through the purchase of supports by the individual, the individual's family, legal representative, or the authorized representative with funds received through the consumer-directed community support service under this section. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

Subd. 16a. **Medical assistance reimbursement.** (a) The commissioner shall seek federal approval for medical assistance reimbursement of independent living skills services, foster care waiver service, supported employment, prevocational service, and structured day service under the home and community-based waiver for persons with a brain injury, the community alternatives for disabled individuals waivers, and the community alternative care waivers.

(b) Medical reimbursement shall be made only when the provider demonstrates evidence of its capacity to meet basic health, safety, and protection standards through the following methods:

(1) for independent living skills services, supported employment, prevocational service, and structured day service through one of the methods in paragraphs (c) and (d); and

(2) for foster care waiver services through the method in paragraph (e).

(c) The provider is licensed to provide services under chapter 245B and agrees to apply these standards to services funded through the brain injury, community alternatives for disabled persons, or community alternative care home and community-based waivers.

(d) The commissioner shall certify that the provider has policies and procedures governing the following:

(1) protection of the consumer's rights and privacy;

(2) risk assessment and planning;

(3) record keeping and reporting of incidents and emergencies with documentation of corrective action if needed;

(4) service outcomes, regular reviews of progress, and periodic reports;

(5) complaint and grievance procedures;

(6) service termination or suspension;

(7) necessary training and supervision of direct care staff that includes:

(i) documentation in personnel files of 20 hours of orientation training in providing training related to service provision;

(ii) training in recognizing the symptoms and effects of certain disabilities, health conditions, and positive behavioral supports and interventions;

(iii) a minimum of five hours of related training annually; and

(iv) when applicable:

(A) safe medication administration;

(B) proper handling of consumer funds; and

(C) compliance with prohibitions and standards developed by the commissioner to satisfy federal requirements regarding the use of restraints and restrictive interventions. The commissioner shall review at least biennially that each service provider's policies and procedures governing basic health, safety, and protection of rights continue to meet minimum standards.

(e) The commissioner shall seek federal approval for Medicaid reimbursement of foster care services under the home and community-based waiver for persons with a brain injury, the community alternatives for disabled individuals waiver, and community alternative care waiver when the provider demonstrates evidence of its capacity to meet basic health, safety, and protection standards. The commissioner shall verify that the adult foster care provider is licensed under Minnesota Rules, parts 9555.5105 to 9555.6265; that the child foster care provider is licensed as a family foster care or a foster care residence under Minnesota Rules, parts 2960.3000 to 2960.3340, and certify that the provider has policies and procedures that govern:

(1) compliance with prohibitions and standards developed by the commissioner to meet federal requirements regarding the use of restraints and restrictive interventions;

(2) documentation of service needs and outcomes, regular reviews of progress, and periodic reports; and

(3) safe medication management and administration.

The commissioner shall review at least biennially that each service provider's policies and procedures governing basic health, safety, and protection of rights standards continue to meet minimum standards.

(f) The commissioner shall seek federal waiver approval for Medicaid reimbursement of family adult day services under all disability waivers. After the waiver is granted, the commissioner shall include family adult day services in the common services menu that is currently under development.

**Subd. 17. Cost of services and supports.** (a) The commissioner shall ensure that the average per capita expenditures estimated in any fiscal year for home and community-based waiver recipients does not exceed the average per capita expenditures that would have been made to provide institutional services for recipients in the absence of the waiver.

(b) The commissioner shall implement on January 1, 2002, one or more aggregate, need-based methods for allocating to local agencies the home and community-based waived service resources available to support recipients with disabilities in need of the level of care provided in a nursing facility or a hospital. The commissioner shall allocate resources to single counties and county partnerships in a manner that reflects consideration of:

(1) an incentive-based payment process for achieving outcomes;

(2) the need for a state-level risk pool;

(3) the need for retention of management responsibility at the state agency level; and

(4) a phase-in strategy as appropriate.

(c) Until the allocation methods described in paragraph (b) are implemented, the annual allowable reimbursement level of home and community-based waiver services shall be the greater of:

(1) the statewide average payment amount which the recipient is assigned under the waiver reimbursement system in place on June 30, 2001, modified by the percentage of any provider rate increase appropriated for home and community-based services; or

(2) an amount approved by the commissioner based on the recipient's extraordinary needs that cannot be met within the current allowable reimbursement level. The increased reimbursement level must be necessary to allow the recipient to be discharged from an institution or to prevent imminent placement in an institution. The additional reimbursement may be used to secure environmental modifications; assistive technology and equipment; and increased costs for supervision, training, and support services necessary to address the recipient's extraordinary needs. The commissioner may approve an increased reimbursement level for up to one year of the recipient's relocation from an institution or up to six months of a determination that a current waiver recipient is at imminent risk of being placed in an institution.

(d) Beginning July 1, 2001, medically necessary private duty nursing services will be authorized under this section as complex and regular care according to sections 256B.0651 to 256B.0656 and 256B.0659. The rate established by the commissioner for registered nurse or licensed practical nurse services under any home and community-based waiver as of January 1, 2001, shall not be reduced.

(e) Notwithstanding section 252.28, subdivision 3, paragraph (d), if the 2009 legislature adopts a rate reduction that impacts payment to providers of adult foster care services, the commissioner may issue adult foster care licenses that permit a capacity of five adults. The application for a five-bed license must meet the requirements of section 245A.11, subdivision 2a. Prior to admission of the fifth recipient of adult foster care services, the county must negotiate a revised per diem rate for room and board and waiver services that reflects the legislated rate reduction and results in an overall average per diem reduction for all foster care recipients in that home. The revised per diem must allow the provider to maintain, as much as possible, the level of services or enhanced services provided in the residence, while mitigating the losses of the legislated rate reduction.

Subd. 18. **Payments.** The commissioner shall reimburse approved vendors from the medical assistance account for the costs of providing home and community-based services to eligible recipients using the invoice processing procedures of the Medicaid management information system (MMIS). Recipients will be screened and authorized for services according to the federally approved waiver application and its subsequent amendments.

Subd. 19. **Health and welfare.** The commissioner of human services shall take the necessary safeguards to protect the health and welfare of individuals provided services under the waiver.

Subd. 20. **Brain injury and related conditions.** The commissioner shall seek to amend the brain injury waiver to include, as eligible persons, individuals with an acquired or degenerative disease diagnosis where cognitive impairment is present, such as multiple sclerosis.

Subd. 21. **Report.** (a) The commissioner shall expand on the annual report required under section 256B.0916, subdivision 7, to include information on the county of residence and financial



responsibility, age, and major diagnoses for persons eligible for the home and community-based waivers authorized under subdivision 11 who are:

- (1) receiving those services;
  - (2) screened and waiting for waiver services; and
  - (3) residing in nursing facilities and are under age 65.
- (b) This subdivision expires January 1, 2013.

**Subd. 22. Residential support services.** For the purposes of this section, the provisions of section 256B.092, subdivision 11, are controlling.

**Subd. 23. Community-living settings.** "Community-living settings" means a single-family home or apartment where the service recipient or their family owns or rents, and maintains control over the individual unit as demonstrated by the lease agreement, or has a plan for transition of a lease from a service provider to the individual. Within two years of signing the initial lease, the service provider shall transfer the lease to the individual. In the event the landlord denies the transfer, the commissioner may approve an exception within sufficient time to ensure the continued occupancy by the individual. Community-living settings are subject to the following:

- (1) individuals are not required to receive services;
- (2) individuals are not required to have a disability or specific diagnosis to live in the community-living setting;
- (3) individuals may hire service providers of their choice;
- (4) individuals may choose whether to share their household and with whom;
- (5) the home or apartment must include living, sleeping, bathing, and cooking areas;
- (6) individuals must have lockable access and egress;
- (7) individuals must be free to receive visitors and leave the settings at times and for durations of their own choosing;
- (8) leases must not reserve the right to assign units or change unit assignments; and
- (9) access to the greater community must be easily facilitated based on the individual's needs and preferences.

**History:** 1984 c 640 s 32; 1984 c 654 art 5 s 24,58; 1990 c 568 art 3 s 76; 1991 c 292 art 4 s 61; 1992 c 513 art 7 s 114; 1Sp1993 c 1 art 5 s 105; 1995 c 207 art 6 s 87-89; 1996 c 451 art 5 s 29-31; 1997 c 7 art 5 s 31; 1997 c 203 art 4 s 47; art 7 s 24; 1999 c 156 s 1; 1Sp2001 c 9 art 3 s 58-67; 2002 c 277 s 32; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 3 s 46; 2004 c 288 art 3 s 25; 2005 c 56 s 1; 1Sp2005 c 4 art 7 s 44; 2007 c 147 art 6 s 45; art 7 s 58; 2008 c 277 art 1 s 39; 2008 c 317 s 2; 2009 c 79 art 1 s 19; art 6 s 13; art 8 s 64-68; 2009 c 173 art 1 s 30; 1Sp2011 c 9 art 4 s 9; art 7 s 38-41; 2012 c 216 art 9 s 29; art 11 s 38-40; art 14 s 2; 2012 c 247 art 4 s 34-36

**NOTE:** Subdivision 14, paragraph (e), as amended by Laws 2011, First Special Session chapter 9, article 7, section 39, is effective July 1, 2013. Laws 2011, First Special Session chapter 9, article 7, section 39, the effective date.

**NOTE:** Subdivision 15, paragraphs (b), (c), and (d), as amended by Laws 2011, First Special Session chapter 9, article 7, section 40, are effective July 1, 2013. Laws 2011, First Special Session chapter 9, article 7, section 40, the effective date.