

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

DEPARTMENT: Office of the Attorney General

STATE OF MINNESOTA

OFFICE MEMORANDUM

DATE: December 12, 1990

TO: ELEANOR WEBER
Rules and Bulletins Division

FROM: MARTHA J. CASSERLY
Special Assistant
Attorney General

PHONE: 296-6839

SUBJECT: In the Matter of the Adopted Rule Relating to Community Alternative Care Program

The above-referenced rule has been approved as to its legality by the Attorney General on December 11, 1990.

Enclosed is your copy of the approved rule. This office has already filed two copies with the Secretary of State, who will forward one copy to the Revisor of Statutes. The fourth is being retained by this division of the Attorney General's Office for its records.

Also enclosed are any petitions, requests, submissions or comments along with any extra copies of documents which you submitted to the Attorney General.

Your next step is to arrange for publication of the Notice of Adoption in the State Register. In a day or two, you should receive from the Revisor's Office three copies of the notice of adoption of your rule. You should submit two copies of the Notice of Adoption to the State Register for publication. A permanent rule without a hearing does not become effective until five days after a notice of adoption is published in the State Register in accordance with Minn. Stat. § 14.27. An emergency rule becomes effective five working days after approval by the Attorney General; however, the agency must publish a notice in the State Register in accordance with Minn. Stat. § 14.34.

If you have any questions in this regard, please contact me.

MJC:sc

cc: Kim Mesun
William Brown, Chief Judge
MaryAnn Hruby

MJC

RULE REVIEW CHECKLIST

File No. 1760 Docket No. 05.0009.0866
DATE RECEIVED 11-27-90 ADOPTED W/O HEARING _____
REVIEW DATE 12-6-90 EMERGENCY RULE _____
DUE DATE 12-11-90 TO REVISOR ON 11-28-90
(DIS)APPROVED 12-11-90 mjc REVISOR (DIS)APPROVED _____
WITHDRAWN _____ FILED W/SEC. OF STATE 12-11-90
RETURNED TO AGENCY _____

✓ Rule as adopted (4 copies)

✓ Notice to Solicit Outside Information/Opinion (if applicable)
March 7, 1988 Date published in State Register
_____ Comments

_____ Petition for Adoption of a Rule

_____ Board's Authorizing Resolution
_____ Date adopted

✓ Proposed Rule
✓ Revisor's Certificate

✓ Notice of Intent to Adopt Rule
256B.49 Statutory Authority
_____ Small Business Statement
_____ Expenditure of public money statement 7-31-90
Ann Wynia Signature

✓ Statement of Need and Reasonableness (if applicable)
NA Small Business Statement
_____ Fees - § 16A.128

✓ Affidavit of Mailing Notice of Intent to Adopt Rule
Aug 15, 1990 Dated (30)/25 days before adoption
✓ Notice attached indicates it is attached
_____ Copy of rule or summary attached

✓ Publication in State Register
August 20, 1990 Date (30)/25 days before adoption

✓ 180-day deadline from:
✓ Effective date of law requiring rule (14/12) (both rules) amendments don't apply may not
_____ end of comment period (§ 14.26) (rules without hearing)
_____ effective date of statutory authority (§ 14.29) (emergency rules) mandatory

_____ ~~Resolution Adopting~~
_____ Date adopted

✓ Findings of Fact, Conclusions & Order Adopting
Nov 26, 1990 Date

✓ Written Requests, Submissions or Comments

✓ Declaration of Attorney
Kim Mueser Name of SAAG representing agency

~~11-29-90~~ Notice of Submission to Attorney General (if applicable) no submissions were requested

_____ Affidavit of Mailing Notice to Attorney General (if applicable)

Department of Human Services

Adopted Permanent Rules Relating to Community Alternative Care Program

Rules as Adopted

COMMUNITY ALTERNATIVE CARE PROGRAM

9505.3500 APPLICABILITY AND EFFECT.

Subpart 1. **Applicability.** Parts 9505.3500 to 9505.3700 establish standards and procedures applicable to the community alternative care (CAC) program. Individuals who are eligible for and receiving medical assistance services may also be eligible for and receive services under the community alternative care program. CAC pays for approved home and community-based services in lieu of hospital admission or continued hospitalization for individuals who meet the requirements of parts 9505.3500 to 9505.3700, Minnesota Statutes, section 256B.49, and the Code of Federal Regulations, title 42, section 441.302(e)(2). Parts 9505.3500 to 9505.3700 must be read in conjunction with Minnesota Statutes, chapter 256B; parts 9500.1070, subparts 1 and 12 to 15; 9500.1090 to 9500.1155; chapter 9505; Title XIX of the Social Security Act; and title 42 of the Code of Federal Regulations; and the requirements of the waiver obtained by the state from the United States Department of Health and Human Services.

Parts 9505.3500 to 9505.3700 apply to local agencies administering medical assistance funds and providing case management services; entities and organizations contracting to perform functions under Minnesota Statutes, 256B.49; providers of home and community-based services who are paid or who request payment under parts 9505.3500 to 9505.3700; and CAC applicants and recipients.

Subp. 2. **Effect.** References to the waiver and waiver provisions that occur in parts 9505.3500 to 9505.3700 shall continue in effect only as long as the waiver from the United

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States Department of Health and Human Services is in effect in Minnesota.

9505.3510 DEFINITIONS.

Subpart 1. **Applicability.** The definitions in this part apply to parts 9505.3500 to 9505.3700.

Subp. 2. **Acting case manager.** "Acting case manager" means a person who is a public health nurse, medical social worker, ~~county~~ social worker, or registered nurse who is appointed by the department and performs case management services specified in subpart 6 for an applicant until the applicant's eligibility for CAC services is determined and a case manager is assigned.

Subp. 3. **Applicant.** "Applicant" means an individual who has submitted an application to participate in the CAC program rather than reside in a hospital or remain at risk of frequent hospitalization.

Subp. 4. **Application.** "Application" means an application to participate in CAC that is completed according to part 9505.3540.

Subp. 5. **Assessment.** "Assessment" means the process an interdisciplinary team uses to identify an applicant's health service needs according to part 9505.3540 so that the team can determine the appropriateness of home and community-based services in meeting the applicant's needs.

Subp. 6. **Case management services.** "Case management services" means services in which a case manager identifies, arranges, authorizes, and coordinates health services including home and community-based services under parts 9505.3500 to 9505.3700 for a recipient; monitors the delivery of services; adjusts services to the needs of the recipient; and advocates for the rights of the recipient.

Subp. 7. **Case manager.** "Case manager" means a social worker, registered nurse, or public health nurse who is employed by or under contract with the lead agency and who performs case management services.

Subp. 8. **Chronically ill individual or individual.**

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"Chronically ill individual" or "individual" means an individual who needs an extensive array of health services for an undetermined period of time, whose health condition requires frequent monitoring and treatment by a health care professional or by a person supervised by a health care professional, and who would reside in a hospital or require frequent hospitalization if these services were not provided.

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

Subp. 10. **Community alternative care program or CAC.** "Community alternative care program" or "CAC" means the program specified in the Minnesota Medicaid model waiver approved by the United States Department of Health and Human Services to provide home and community-based services to chronically ill individuals under age 65.

Subp. 10a. **Counseling and training services.** "Counseling and training services" means counseling and training approved by the case manager for primary caregivers in issues pertaining to the maintenance of the recipient in the home. Examples of counseling are crisis counseling and family or individual counseling as required for family functioning. An example of training is teaching a family member or other primary caregiver a treatment regimen or how to use medical equipment or other adaptive equipment necessary to avoid institutionalization.

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 that performs or arranges services for recipients under parts 9505.3500 to 9505.3700. County of service may be either the county of financial responsibility or the county in which the recipient resides.

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

Subp. 14. **Durable medical equipment.** "Durable medical

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equipment" means a device that can withstand repeated use, is provided to correct or accommodate a physiological disorder or physical condition, and is suitable for use in the recipient's residence.

Subp. 15. **Environmental modifications in the home.** "Environmental modifications to the home" means structural changes to a recipient's residence that are prescribed in the recipient's care plan and that are necessary to maintain the recipient in the recipient's home. Examples of environmental modifications are changes in electrical wiring to accommodate equipment, construction of wheelchair ramps, and widening of doors.

Subp. 16. **Foster care services.** "Foster care services" means ongoing residential care and supportive services provided to a recipient living in a foster home licensed under parts 9545.0010 to 9545.0260; or 9555.5105 to 9555.6265.

Subp. 17. **Health care professional.** "Health care professional" means a physician, registered nurse, licensed practical nurse, occupational therapist, physical therapist, respiratory therapist, or a speech-language pathologist.

Subp. 18. **Health service.** "Health service" means a medically necessary service that is ordered by a physician, documented in an approved care plan, and provided to a recipient as ordered in the care plan. The term includes home and community-based services and services provided under parts 9505.0170 to 9505.0475.

Subp. 19. **Home.** "Home" means the recipient's residence as defined in part 9505.0175, subpart 43. "Home" does not include a hospital or long-term care facility.

Subp. 20. **Home and community-based services.** "Home and community-based services" means the services listed in items A to L that are available under the waiver to recipients:

A. case management services under part 9505.3560;

B. home health services under part 9505.3570;

C. homemaker services under part 9505.3575;

D. respite care services under part 9505.3580;

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E. physician services under part 9505.3585;

F. family counseling and training under part 9505.3600;

G. environmental modifications in the home under part 9505.3610;

H. medical equipment under part 9505.3620;

I. medical transportation under part 9505.3622;

J. prescribed drugs under part 9505.3624;

K. other professional services under part 9505.3626; and

L. foster care services under part 9505.3630.

Subp. 21. **Home care plan or care plan.** "Home care plan" or "care plan" means the written plan of health services provided to a recipient that are necessary to maintain a recipient in the recipient's home.

Subp. 22. **Home health aide.** "Home health aide" means a person who meets the standards for a home health aide in part 9505.0290, subpart 3.

Subp. 23. **Homemaker.** "Homemaker" means a person who provides homemaker services and is qualified according to part 9565.1200, subpart 2.

Subp. 24. **Homemaker services.** "Homemaker services" means the activities specified in parts 9565.1100 and 9565.1200 that are prescribed in the recipient's care plan and provided by a homemaker.

Subp. 25. **Hospital.** "Hospital" has the meaning given in Minnesota Statutes, section 144.696, subdivision 3.

Subp. 26. **Interdisciplinary team or team.** "Interdisciplinary team" or "team" means a team specified in part 9505.3535 that is responsible for developing a home care plan for an applicant or for a recipient.

Subp. 27. **Lead agency.** "Lead agency" means the county welfare department or public health agency designated by the local agency to administer CAC.

Subp. 28. **Licensed practical nurse.** "Licensed practical nurse" means a person licensed under and providing health

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services within the scope of Minnesota Statutes, section 148.29.

Subp. 29. **Local agency.** "Local agency" means the county or multicounty agency that is authorized under Minnesota Statutes, section 256B.05 to administer the medical assistance program, including the community alternative care program.

Subp. 30. **Medical assistance.** "Medical assistance" means the program established under title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

Subp. 31. **Medical social worker.** "Medical social worker" means a graduate of a school of social work accredited by the Council on Social Work Education who has had social work experience in a hospital, outpatient clinic, medical rehabilitation, or medical care program.

Subp. 32. **Medically necessary.** "Medically necessary" has the meaning given in part 9505.0175, subpart 25.

Subp. 33. **Nondurable medical equipment.** "Nondurable medical equipment" means a supply or piece of equipment that is used to treat a health condition and that cannot be reused.

Subp. 34. **Nursing services.** "Nursing services" means services ordered by a physician, specified in the recipient's care plan, and provided by a licensed practical nurse or provided by a registered nurse or provided under the supervision of a registered nurse.

Subp. 35. **Nutritionist.** "Nutritionist" means a person who at a minimum has a bachelor's degree in nutrition and foods or a closely related field and is registered as a dietitian with the Commission of Dietetic Registration.

Subp. 36. **Occupational therapist.** "Occupational therapist" means a person who is currently registered as an occupational therapist with the American Occupational Therapy Association or who is a graduate of a program in occupational therapy approved by the Council of Medical Education of the American Medical Association in collaboration with the American Occupational ~~Therapy Association~~ Certification Board and who is acquiring the supervised clinical experience prerequisite to registration by the American Occupational Therapy Association.

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Subp. 37. **Physical therapist.** "Physical therapist" means a person holding a current Minnesota certificate of registration as a physical therapist.

Subp. 38. **Physician.** "Physician" means a person who is licensed to provide health services within the scope of the physician's profession under Minnesota Statutes, chapter 147.

Subp. 39. **Prescribed drug.** "Prescribed drug" means a drug as defined in Minnesota Statutes, section 151.01, subdivision 5, ~~ordered~~ authorized by the recipient's physician, and specified in the recipient's care plan.

Subp. 40. **Primary caregiver.** "Primary caregiver" means the person designated by the individual as having the main role in providing informal care to the individual. Primary caregiver includes a family member, relative, friend, neighbor, and other person, who agrees to provide routine care and assistance to the recipient without reimbursement for the services and who cooperates with the case manager and other providers in assuring that services specified in the recipient's care plan are provided.

Subp. 41. **Provider.** "Provider" means a vendor who has an agreement or contract with the lead agency to provide a home and community-based service as specified in subpart 20.

Subp. 42. **Public health nurse.** "Public health nurse" means a registered nurse ~~certified~~ who meets the requirements of Minnesota Statutes, section 148.232, or the voluntary registration requirements established by the Minnesota ~~Department~~ Board of ~~Health as a public health nurse~~ Nursing under Minnesota Statutes, section ~~145A.02, subdivision 18~~ 148.171, paragraph (8).

Subp. 43. **Reassessment.** "Reassessment" means the interdisciplinary team's formal redetermination of a recipient's home and community-based service needs under part 9505.3545.

Subp. 44. **Recipient.** "Recipient" means an individual determined to be eligible to receive home and community-based services under a care plan that meets the requirements of part 9505.3520 and that is approved by the commissioner under part

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9505.3680.

Subp. 45. **Registered nurse.** "Registered nurse" means a person licensed under and providing services within the scope of Minnesota Statutes, section 148.211.

Subp. 46. **Representative.** "Representative" means a person appointed by a court as a guardian or conservator under Minnesota Statutes, sections 252A.01 to 252A.21, or 525.539 to 525.6198; a parent of a child under age 21 unless the parent's parental rights have been terminated; or a spouse or other person authorized by the applicant or recipient as defined in part 9505.0015, subpart 8.

Subp. 47. **Respiratory therapist.** "Respiratory therapist" means a person who is a graduate of a program in respiratory therapy approved by the Council of Medical Education of the American Medical Association in collaboration with the American Respiratory Therapy Association. If the legislature acts to require certification, registration, or licensure of respiratory therapists, "respiratory therapist" means a person certified, registered, or licensed as a respiratory therapist by the state of Minnesota.

Subp. 48. **Respite care services.** "Respite care services" means temporary supervision, assistance, and care provided to a recipient as specified in part 9505.3580 to relieve the recipient's primary caregiver, or other informal caregiver.

Subp. 49. **Social worker.** "Social worker" means an individual who meets the minimum qualifications of a social worker under the Minnesota Merit System or a county civil service system in Minnesota and who is employed as a social worker by a county.

Subp. 50. **Speech therapist or speech-language pathologist.** "Speech therapist" or "speech-language pathologist" means a person holding a current certificate from the American Speech-Language-Hearing Association in evaluation and treatment of speech-language pathologies or who has completed the academic requirements and is acquiring the supervised work experience required for certification.

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Subp. 51. **Transportation.** "Transportation" means transportation that is necessary because of the recipient's health service needs, that is indicated in the recipient's care plan or is approved by the recipient's case manager, and that is not eligible for medical assistance payment under parts 9505.0010 to 9505.0475.

Subp. 52. **Waiver.** "Waiver" means the document approved by the United States Department of Health and Human Services that allows the state to exclude parental or spousal income when determining an applicant's eligibility for medical assistance and to extend services under medical assistance as specified in parts 9505.3500 to 9505.3700. The term includes all amendments to the waiver, including any amendments after the effective date of parts 9505.3500 to 9505.3700, as approved by the United States Department of Health and Human Services.

Subp. 53. **Waiver year.** "Waiver year" means April 1 to March 31.

Subp. 54. **Working day.** "Working day" means the hours of a day, excluding Saturdays, Sundays, and holidays, when a lead agency is open for business.

9505.3520 ELIGIBILITY FOR COMMUNITY ALTERNATIVE CARE SERVICES.

An individual is eligible for home and community-based services through CAC if the conditions in items A to I are met.

A. The individual is eligible for medical assistance as specified in part 9505.3640, subpart 1.

B. The individual is under 65 years of age.

C. The individual needs a home and community-based service which cannot be funded by sources other than CAC.

D. The individual has designated a primary caregiver who has been determined by a health care professional <u>in coordination with the case manager</u> to be capable of providing specific health services to the individual in the individual's residence and has expressed a willingness to provide the specific health services according to the individual's care plan.

E. The primary physician has certified that the

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individual would reside in a hospital or would require frequent hospitalization without home and community-based services.

F. The anticipated average monthly cost to the medical assistance program to implement the individual's care plan, determined on a twelve-month basis, must not exceed the cost to medical assistance of providing inpatient hospital services and physician services for the individual.

G. An individual who is eligible for inpatient hospital service financial coverage by a third party payer and medical assistance is eligible for CAC services if the anticipated medical assistance payment for the CAC services is within the limit specified in item F. For purposes of this item, "third party payer" refers to Medicare and a person, entity, agency, or government program as defined in part 9505.0015, subpart 46.

H. The cost to medical assistance of CAC services specified in the individual's care plan falls within the limit specified in the waiver for the aggregate annual cost of CAC services provided under the waiver for the waiver year in which the individual is a recipient.

I. The total number of recipients to be served, including the applicant if approved, falls within the limit specified in the waiver.

9505.3530 REQUEST FOR CAC SERVICES.

Subpart 1. **Who may request service.** An individual or the representative of an individual who believes that the individual meets the criteria of part 9505.3520, items A to I may request participation in CAC according to parts 9505.3500 to 9505.3700. The request must be made to the department.

Subp. 2. **Response of department to request for CAC.** When the department receives a request for a determination of eligibility for CAC, the department shall determine which county will be the individual's county of financial responsibility and the estimated date or dates for the start of the individual's home and community-based services. The department shall

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designate an acting case manager and send the acting case manager the forms necessary to obtain the information required under part 9505.3540. The forms must be sent no later than five working days after receiving the request. If the acting case manager is not employed by the local agency of the applicant's county of service, the department shall notify the local agency about the request to participate in CAC and the designation of an acting case manager.

Subp. 3. **Local agency designation of team members.** No later than five working days after receiving the department's notice, the local agency of the applicant's county of service must designate a social worker and public health nurse to serve on the interdisciplinary team required under part 9505.3535.

9505.3535 INTERDISCIPLINARY TEAMS; ESTABLISHMENT AND MEMBERSHIP.

Subpart 1. **Applicant's interdisciplinary team.** No later than ten working days after being designated as an applicant's acting case manager, the acting case manager must form an interdisciplinary team. The acting case manager shall consult the applicant or, when it is appropriate, the applicant's representative in forming the team. The team must consist of at least the persons specified in items A to K.

A. the applicant or, when it is appropriate, the applicant's representative;

B. the acting case manager;

C. the applicant's physician;

D. the applicant's primary nurse;

E. in the case of an applicant who is an inpatient, a medical social worker designated by the hospital to assist in discharge planning for the applicant;

F. the ~~county~~ social worker designated under part 9505.3530, subpart 3;

G. the county public health nurse designated under part 9505.3530, subpart 3;

H. a representative of Services for Children with Handicaps if the applicant is under 21 years of age;

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I. when it is appropriate, other persons who are expected to be the applicant's informal caregivers;

J. a representative of the local school district if the applicant is under 22 years of age; and

K. other health care professionals providing services required by the applicant's medical condition, consistent with part 9505.0190 and Code of Federal Regulations, title 42, section 431.51.

Subp. 2. **Interdisciplinary team; reconvened.** The case manager must reconvene the interdisciplinary team established under subpart 1 when a reassessment is required to determine a recipient's continued eligibility for CAC. If possible, the case manager shall assure continuity of service of team members. At a minimum, the reconvened team must include the persons specified in items A to I.

A. the recipient or, when it is appropriate, the recipient's representative;

B. the case manager;

C. the recipient's primary caregiver;

D. the recipient's physician;

E. the ~~county~~ social worker designated under part 9505.3530, subpart 3;

F. the county public health nurse designated under part 9505.3530, subpart 3;

G. a representative of Services for Children with Handicaps if the recipient is under 21 years of age;

H. a representative of the local school district if the recipient is under 22 years of age; and

I. other health care professionals providing services required by the recipient's medical condition, consistent with part 9505.0190 and Code of Federal Regulations, title 42, section 431.51.

9505.3540 INTERDISCIPLINARY TEAM RESPONSIBILITIES; ASSESSMENT.

Subpart 1. **Assessment of applicant's service needs.** The team must assess the home and community-based services that an

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applicant will need to live in the community. The assessment must be completed on forms provided by the commissioner.

Subp. 2. **Assessment of financial resources.** The team must assess an applicant's financial resources to identify third party payers and other financial resources as defined in part 9505.0015, subpart 46, using forms provided by the commissioner.

Subp. 3. **Assessment of the applicant's home.** The team must assess the home in which the applicant lives or will live to determine if the applicant's health and safety can be assured in the residence. This assessment must be completed on forms provided by the commissioner. The assessment shall include a determination of the need for environmental modifications in the home as specified in part 9505.3610.

Subp. 4. **Assessment of person to be primary caregiver.** The team must assess the willingness and ability of the person who is expected to be the CAC applicant's primary caregiver. The team must report its assessment under this subpart on the form provided by the commissioner.

Subp. 5. **Authorization to release information.** The team must ask the applicant or the applicant's representative to sign forms that authorize the release of the applicant's medical records to the team for the assessment. A separate form ~~supplied~~ provided by the commissioner must be completed and signed for each authorization of release of information. The period of the authorization must not exceed one year. The following information must be on the form before the applicant's signature or, when it is appropriate, the signature of the applicant's representative:

A. the applicant's name;

B. the date of the authorization;

C. the information authorized;

D. the person authorized to give the information;

E. the person to whom the information is to be given;

F. a description of how the information will be used during the assessment to determine the appropriateness of CAC services; and

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G. the date the authorization expires.

Subp. 6. **Rights, appeals, and freedom to choose.** The team must give the applicant or the applicant's representative written information about the applicant's rights under CAC including:

A. the right to appeal the assessment;

B. the right to choose among qualified providers of home and community-based services, consistent with part 9505.0190 and Code of Federal Regulations, title 42, section 431.51;

C. the right to confidentiality; and

D. the right to accept or reject a recommendation of the team to use home and community-based services rather than reside in a hospital.

The acting case manager must document compliance with this subpart by signing and submitting to the department forms ~~supplied~~ provided by the commissioner that state the required information was given to the applicant or, when it is appropriate, the applicant's representative.

Subp. 7. **Development of a care plan.** The interdisciplinary team shall develop a care plan for the applicant that is based on the information obtained in subparts 1 to 5. The plan must meet the requirements of subpart 8. The acting case manager must notify the department and estimate the additional time needed if the time required to complete the care plan and assessments required under this subpart exceeds the time specified in part 9505.0090, subpart 2. The applicant's care plan must be signed by the applicant or, when it is appropriate, the applicant's representative, the applicant's physician, and the acting case manager.

Subp. 8. **Contents.** The care plan developed by the interdisciplinary team for an applicant or recipient must contain at least the information specified in items A to D. The plan must be on forms provided by the commissioner. The care plan must include all health services approved by the individual's physician regardless of the funding source or

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sources available to pay the cost of the health services.

A. The recommendation of the team that the applicant be approved for services funded by CAC because the applicant meets the eligibility criteria under part 9505.3520 or, in the case of a recipient, continues to be approved for services funded by CAC because the applicant continues to meet the eligibility criteria under part 9505.3520.

B. A description of the health services necessary to maintain the individual in the community, including:

(1) home and community-based services needed by the individual;

(2) qualified providers of the home and community-based services selected by the applicant or, when it is appropriate, the applicant's representative or, in the case of a recipient, by the recipient or, when it is appropriate, the recipient's representative to meet the needs identified in subitem (1);

(3) the informal caregivers who are willing and able to provide services identified in subitem (1);

(4) the required frequency of the services;

(5) the anticipated date or dates on which the applicant's services must be started;

(6) the provisions for back-up services if there is an emergency;

(7) the cost of each service;

(8) the funding source for each service; and

(9) an estimate of the total cost of all health services in the care plan including home and community-based services.

C. Documentation that the team allowed the applicant or recipient or, when it is appropriate, the representative of the applicant or recipient to choose among the available qualified providers.

D. Documentation that the applicant or recipient or, when it is appropriate, the representative of the applicant or recipient, the acting case manager or case manager, and the

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physician of the applicant or recipient approve the home care plan.

Subp. 9. **Team recommendation.** After completing the assessments required in subparts 1 to 4 and the care plan required in subpart 8, the interdisciplinary team must recommend one of the following:

A. that the applicant remain a hospital inpatient;

B. that the applicant be admitted to a facility from the applicant's home. For purposes of this item, "facility" means a hospital as defined in part 9505.0175, subpart 16 or a long-term care facility as defined in part 9505.0175, subpart 23; or

C. that the applicant receive health services including home and community-based services in the community.

The team's recommendation must be supported by the assessments conducted under subparts 1 to 4 and the services specified in the applicant's care plan. The applicant's physician, the acting case manager or case manager and the applicant or, when it is appropriate, the applicant's representative must sign the application.

Subp. 10. **Transmittal of plan, assessments, and recommendations to the commissioner.** The team must submit the following documents to the commissioner for a determination of the applicant's eligibility for CAC services:

A. the completed assessments required under subparts 1 to 4;

B. the documentation required under subpart 6;

C. the request for CAC services, signed by the applicant or the applicant's representative;

D. the recommendation required under subpart 9; and

E. the care plan signed by the physician, case manager, and the applicant or the applicant's representative.

9505.3545 REASSESSMENT BY INTERDISCIPLINARY TEAM.

Subpart 1. **Reassessment required.** A recipient's need and eligibility for home and community-based services must be

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reassessed at least once every six months. The reassessment must be carried out by an interdisciplinary team convened by the recipient's case manager as specified in part 9505.3535, subpart 2. At a minimum, the reassessment shall include the items specified in part 9505.3540, subparts 1 and 3 to 9. The team must review and modify the recipient's care plan as necessary and appropriate to meet the recipient's needs.

Subp. 2. **Responsibility to assure reassessment.** A local agency is responsible to assure that a recipient's reassessment is completed as required under subpart 1. If the reassessment is not completed, the local agency shall be responsible for paying the costs of the services specified in the recipient's care plan and received by the recipient until the reassessment is completed and submitted to the department.

9505.3550 RECIPIENT'S TERMINATION FROM CAC.

A recipient shall be terminated from eligibility for CAC services when:

A. the recipient chooses not to use CAC services;

B. the recipient no longer needs CAC services as determined by a reassessment;

C. the recipient's condition requires continued hospitalization for an indefinite period as certified by the recipient's physician;

D. the recipient who has been hospitalized more than 30 consecutive days in a waiver year requires home and community-based services that are not available in the community;

E. the recipient is no longer eligible for medical assistance;

F. the recipient has third party payer coverage that pays the cost of inpatient hospital services to the extent CAC services are no longer cost-effective; or

G. the recipient's condition requires health services having a cost to medical assistance that is greater than the medical assistance cost of inpatient hospital services to the

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recipient.

9505.3560 CASE MANAGEMENT SERVICES.

Subpart 1. **Required service.** Case management services must be provided to a recipient. The lead agency shall be responsible for implementing the case management services required under parts 9505.3500 to 9505.3700.

Subp. 2. **Designation of case manager.** No later than five working days after receiving the department's notice that an applicant's request for CAC services has been approved, the lead agency must consult with the applicant or the applicant's representative and designate a case manager. The case manager must not have a financial interest in the services provided to the applicant other than the case manager's employment by the lead agency.

Subp. 3. **Case manager responsibilities.** The case manager or, when it is appropriate, the acting case manager must:

A. convene and coordinate the interdisciplinary team;

B. gather information needed to determine an individual's eligibility for CAC under parts 9505.3500 to 9505.3700;

C. inform applicants, recipients, and their representatives about the rights specified in part 9505.3540, subpart 6 and CAC services;

D. complete and submit forms required by the commissioner under parts 9505.3500 to 9505.3700;

E. locate resources that are available to provide the services specified in the recipient's care plan;

F. coordinate and arrange services specified in the recipient's care plan;

G. seek out other home and community-based services that may contribute to the recipient's quality of life while the recipient is residing in the community but that are not reimbursable under medical assistance or CAC. Examples of other services include legal, recreational, educational, vocational, and social services;

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H. meet with the recipient or the recipient's representative in the recipient's home as necessary to assure the recipient's safety and welfare and assure implementation of the recipient's services as specified in the recipient's care plan;

I. revise the care plan if the recipient's needs change between scheduled reassessments and, when it is appropriate, obtain the approval of the recipient's physician;

J. monitor costs of services to assure that the cost of the services specified in the care plan does not exceed the approved estimated cost of the care plan;

K. investigate whether the costs of the services specified in the applicant's or recipient's care plan can be met by a third party payer other than medical assistance or CAC. The case manager must document the investigation on the applicant's or recipient's care plan;

L. reconvene the interdisciplinary team at least every six months as required under part 9505.3545 or more often if necessary because of changes in the recipient's health or social needs;

M. participate in the recipient's reassessment as required under part 9505.3545 and submit the reassessment form to the department no later than ten working days after the reassessment is completed;

N. submit the care plan and revisions of the care plan to the commissioner for approval;

O. send to the department the information needed to carry out responsibilities under 9505.3680, subparts 1 and 2;

P. give notice of acceptance or rejection of an application or reduction, denial, or termination of benefits; and

Q. request the applicant, recipient, or the representative of the applicant or recipient, and the individual's physician to approve and sign the individual's care plan.

The information required in items N, O, and Q must be provided

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on forms provided by the commissioner. An applicant or recipient is ineligible for CAC services if the applicant or recipient or, when it is appropriate, the applicant's or recipient's representative fails to sign the care plan. The acting case manager of an applicant or the case manager of a recipient must explain to the person whose signature is being requested the consequences of failing to sign.

Subp. 4. **Case manager reports about suspected abuse of a vulnerable adult.** A case manager who has reason to believe a recipient is or has been subject to abuse or neglect as defined in Minnesota Statutes, section 626.557, subdivision 2, that occurs at the recipient's residence or a place where the recipient receives CAC services shall immediately comply with the reporting and other actions required under Minnesota Statutes, section 626.557. The case manager shall cooperate with the responsible county authority to assure the recipient's health and safety during the investigation. The case manager must request a report from the responsible county authority in order to take the action required in subpart 6.

Subp. 5. **Case manager reports about suspected abuse of a child.** A case manager who has reason to believe a recipient who is a child is or has been subject to abuse or neglect as defined in Minnesota Statutes, section 626.556 shall immediately report the circumstances of alleged abuse or neglect to the county authority responsible for assuring the protection of children. The case manager shall cooperate with the responsible county authority to assure the recipient's health and safety during the investigation. The case manager must request a report from the responsible county authority in order to take the action required in subpart 6.

Subp. 6. **Other actions required of case manager.** When the case manager receives the findings of the investigation carried out under subpart 4 or 5, the case manager shall determine whether a reassessment of the recipient according to part 9505.3545 is needed to amend the recipient's care plan. The case manager shall take other actions as needed to assure the

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recipient's health and safety, such as (1) arranging for the services of another CAC provider, (2) working out another living arrangement for the recipient or, (3) withdrawing the CAC service or services. The case manager shall forward the amended care plan to the commissioner for approval.

9505.3570 HOME HEALTH SERVICES.

Home health services established under parts 9505.0170 to 9505.0475 are available to a recipient except that the limits placed on the amount, duration, and scope of the services eligible for medical assistance payment shall be as specified in the recipient's plan of care.

9505.3575 HOMEMAKER SERVICES.

Subpart 1. **Eligibility for service.** Homemaker services are available under CAC if necessary to enable a recipient to remain in the community.

Subp. 2. **Homemaker services provider; lead agency or contractor.** The lead agency may provide directly or may contract for homemaker services that are specified in the recipient's care plan. If the lead agency directly provides homemaker services, 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.

Subp. 3. **Homemaker service standards.** The lead agency shall assure that homemaker services to a recipient are provided by the homemaker according to parts 9565.1000 to 9565.1300 and the recipient's care plan.

9505.3580 RESPITE CARE SERVICES.

Subpart 1. **Eligibility for service.** Respite care services are available under CAC if the service is necessary to maintain the recipient during a time when the primary caregiver is unable to care for the recipient. Respite care services to a recipient are limited to 720 hours per waiver year.

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Subp. 2. **Provider standards.** Respite care may be provided in an out-of-home setting as specified in item A or in the recipient's home as specified in item B.

A. Out-of-home respite care must be provided in a facility approved by the lead agency such as a hospital, nursing home, foster home, or community residential facility. When out-of-home respite care is provided, the facility must be one that meets state licensure standards.

B. A registered nurse or a public health nurse may give respite care in the recipient's home. The person providing respite care services must act in the place of the primary caregiver and shall be available to the recipient throughout the absence of the primary caregiver.

Subp. 3. **Contract required.** The lead agency shall contract with each person, facility, agency, or entity that provides respite care services. If the respite care is provided in the recipient's home, the contract must require the service to be provided as specified in subpart 2, item B. Additionally, the contract must include the authority of the person providing the respite care to act in the event of an emergency affecting the recipient or the recipient's home or must include the name of the person designated by the primary caregiver to act on behalf of the primary caregiver in the event of such an emergency. The lead agency shall monitor the contractor's compliance with the terms of the contract.

9505.3585 PHYSICIAN SERVICES.

Physician services as specified in part 9505.0345 to a CAC recipient may include home visits as necessary to maintain the recipient's safe care in the community.

9505.3600 COUNSELING AND TRAINING SERVICES.

Subpart 1. **Eligibility to receive counseling and training services.** Counseling and training services are available under CAC and shall be provided to a recipient, primary caregiver, and to members of the recipient's family with whom the recipient lives or who routinely care for the recipient. For purposes of

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this part, "member of the recipient's family" or "family member" refers to the recipient's parent, spouse, children, friends, relatives, foster family, or relatives-in-law. The term does not include individuals who are employed to care for the recipient.

Subp. 2. **Purpose of training.** The training must be for the purpose of increasing the ability of a primary caregiver or a member of the recipient's family to maintain and care for the recipient at home. It shall include the use of equipment and treatment regimens as specified in the recipient's care plan and training updates as may be necessary to safely maintain the recipient at home.

Subp. 3. **Purpose of counseling.** Counseling under CAC must be designed to help the recipient, the primary caregiver, and the recipient's family members handle crises related to the recipient's condition, develop coping strategies related to the recipient's daily care, and reduce stress.

Subp. 4. **Case manager approval required.** Counseling and training services under CAC must be approved by the case manager and must be specified in the recipient's care plan.

Subp. 5. **Eligibility to provide counseling and training.** A person providing counseling and training services to a recipient, a primary caregiver, or a recipient's family member must be the recipient's physician, a registered nurse, a public health nurse, a ~~county~~ social worker, or a medical social worker, or other qualified person as specified in the recipient's care plan and approved by the case manager. The person providing training service must determine and must document in the recipient's care plan whether a person being trained as the primary caregiver is competent to provide the services required to maintain the recipient at home.

9505.3610 ENVIRONMENTAL MODIFICATIONS IN THE HOME.

Subpart 1. **Eligibility for service.** An environmental modification in the home of a recipient is available under CAC if the modification is:

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A. necessary to avoid the recipient's hospitalization;

B. approved and authorized by the recipient's case manager;

C. specified in the recipient's care plan; and

D. not available from another funding source.

Examples of other funding sources are Services for Children with Handicaps and the Minnesota Housing Finance Agency.

Subp. 2. **Provider standards.** An environmental modification to the home must be completed according to all applicable state and city building codes by a provider who has been approved by the case manager. The lead agency shall specify the terms of the service to be provided in a contract or service agreement between the agency and the provider approved by the case manager. The lead agency must assure that the environmental modification in the home, when completed, meets the terms specified in the contract or service agreement between the lead agency and the provider.

9505.3620 MEDICAL EQUIPMENT.

Subpart 1. **Eligibility for medical equipment and supplies.** Medical equipment and supplies that are generally available to an individual in an institution are available under CAC for home use if:

A. the medical equipment and supplies are specified in the recipient's plan of care;

B. CAC is the only funding source available to the recipient in regard to the medical equipment and supplies; and

C. the medical equipment and supplies meet the requirements of part 9505.0310 in regard to rental, purchase, and safeguarding of recipient care.

Subp. 2. **Prior approval required.** Medical equipment and supplies require prior approval of the commissioner if:

A. they are not in the recipient's care plan approved by the commissioner under part 9505.3550;

B. they are medically necessary;

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C. they exceed $25 in value per month; and

D. CAC is the only funding source for the medical equipment and supplies.

The case manager must submit to the commissioner an addendum to the recipient's care plan that documents compliance with this subpart. The commissioner shall determine whether the medical equipment and supplies meet the requirements of parts 9505.3500 to 9505.3700.

Subp. 3. **Exemption from limitation on type of equipment and supplies available.** The limitations on the types of equipment or supplies set in part 9505.0310, subpart 1, item A, and subpart 4, item A do not apply to durable medical equipment and supplies available under CAC.

9505.3622 MEDICAL TRANSPORTATION.

Transportation of a recipient for medical purposes is available under CAC if the transportation is specified in the recipient's care plan to provide access to a medically necessary service and if the transportation lies outside the scope of the local agency's procedure to assure access as required under part 9505.0140, subpart 2.

9505.3624 PRESCRIBED DRUGS.

Subpart 1. **Eligibility for service.** Prescribed drugs are available under CAC if the drug is ~~prescribed~~ authorized by the recipient's physician, is specified in the recipient's care plan, and would be available under medical assistance to the recipient as an inpatient, as provided by Minnesota Statutes, section 256B.0625, subdivision 13.

Subp. 2. **Number of prescribed drugs available to recipient.** The availability of prescribed drugs under CAC is subject to the limitations under part 9505.0340. However, the number of different prescribed drugs that a recipient may fill or refill per month is not limited.

9505.3626 OTHER PROFESSIONAL SERVICES; THERAPY.

Subpart 1. **Eligibility for other professional services;**

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therapies available as medical assistance services. A recipient is eligible for a therapy that is available to medical assistance recipients under part 9500.1070. The therapy must be provided by a physical therapist, occupational therapist, speech-language pathologist, or respiratory therapist. The therapy provided to the recipient must comply with the provider standards set in parts 9500.1070 and 9505.3500 to 9505.3700.

Subp. 2. **Eligibility for other professional services; nutritional therapy.** Nutritional therapy is available under CAC. The therapy must be provided by a nutritionist.

Subp. 3. **Service limitations.** The amount, duration, and scope of therapy provided to a recipient by a physical therapist, occupational therapist, speech-language pathologist, respiratory therapist, or nutritionist must be ordered by the recipient's physician and specified in the recipient's care plan.

9505.3630 FOSTER CARE.

Subpart 1. **Eligibility for payment.** Foster care services to a recipient are available under CAC if the services provide ongoing residential and support services which exceed the scope of the services provided through Title IV-E or the Minnesota Supplemental Aid Program. Payment does not include room and board. For purposes of this part, "Title IV-E" means the federal program established by the Social Security Act that reimburses administrative and training costs incurred in providing services under United States Code, title 42, sections 470 to 479 and 670 to 679. "Minnesota Supplemental Aid Program" means the program established in Minnesota Statutes, section 256D.37.

Subp. 2. **Provider standards.** A provider of foster care services must comply with a standard specified in item A or B.

A. A provider of foster care services to a recipient under 18 years of age must be licensed according to parts 9545.0010 to 9545.0260.

B. A provider of foster care services to a recipient who is at least 18 years of age must be licensed according to

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parts 9555.5105 to 9555.6265.

9505.3635 EXCLUDED SERVICES.

The following services in items A to F are not available under CAC:

A. room and board except for respite care provided outside of the recipient's residence;

B. respite care for a recipient of foster care provided under CAC if the payment agreement with the foster care provider includes the payment amount for the respite care to be purchased by the foster care provider;

C. health services for which other funding sources are available;

D. a CAC service to an individual who is not a recipient;

E. a CAC service that is not specified in the recipient's care plan as approved by the commissioner or, in the case of medical transportation under part 9505.3622, the approval of the recipient's case manager; and

F. a CAC service for a purpose other than respite care while a recipient is an inpatient as defined in part 9505.0175, subpart 17.

9505.3640 LOCAL AGENCY RESPONSIBILITIES.

Subpart 1. **Determination of applicant's eligibility for medical assistance.** A local agency must determine a CAC applicant's eligibility for medical assistance and must redetermine a recipient's eligibility for medical assistance. The determination and redetermination shall be as specified in parts 9505.0010 to 9505.0150, except that the provisions of part 9505.0075 relating to the availability of parental or spousal income and assets shall not apply. Although the local agency making the determination must be the local agency of the applicant's or recipient's county of financial responsibility, the local agency obtaining the information required under parts 9505.0010 to 9505.0150 may be the local agency in the county of service.

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Subp. 2. **Designation of lead agency.** A local agency that is the county of service for a CAC applicant or recipient must designate a lead agency to administer the county's community alternative care program. The designated lead agency may be in the recipient's county of residence or service if different from the county of financial responsibility.

Subp. 3. **Calculation of parental or spousal contribution.** ~~The local agency must determine the financial contribution to be made by a recipient's parent or spouse, as appropriate, for services to the recipient.~~ The financial contribution of a parent or spouse shall be determined according to Minnesota Statutes, sections 256B.14 and 252.27, and appropriate rules adopted under those statutes. The refusal or failure of a recipient's obligated parent or spouse to pay the contribution does not affect the recipient's eligibility for medical assistance and CAC.

~~The local agency of the recipient's county of financial responsibility shall refer the refusal or failure to pay to the county attorney for action to enforce payment of the contribution.~~

If the department or the local agency finds that the obligated parent or spouse refused or failed to pay the determined contribution, a cause of action against the obligated parent or spouse may be initiated as authorized in Minnesota Statutes, sections 252.27 and 256B.14.

9505.3645 LEAD AGENCY RESPONSIBILITIES.

Subpart 1. **Enrollment as CAC provider.** A lead agency must enroll under part 9505.0195 as a provider of CAC services.

Subp. 2. **Compliance with rules and local agency requirements.** A lead agency must comply with the requirements of parts 9505.3500 to 9505.3700 and the local agency that made the designation under part 9505.3640, subdivision 2.

Subp. 3. **Administrative functions.** A lead agency is responsible to perform the following functions in regard to CAC services to a recipient:

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A. establish agreements and contracts to provide the recipient's CAC services as in part 9505.3650, subpart 2;

B. review CAC provider billings for approval for payment according to the provider's contract, purchase agreement, or service agreement with the lead agency;

C. furnish billings for CAC services according to the procedures of part 9505.0450;

D. ensure that the projected cost to medical assistance for the services specified in the recipient's care plan does not exceed the cost to medical assistance if the recipient resided in a hospital;

E. make available to the commissioner records of funds expended for CAC services; and

F. maintain and make available to the commissioner records of health services provided to recipients.

Subp. 4. **Services to recipient.** A lead agency must assure that necessary safeguards are taken to protect the health and welfare of a recipient. For this purpose, the lead agency must:

A. require CAC services to be provided as specified in parts 9505.3500 to 9505.3700, either directly or through a contract or purchase of service agreement as specified in part 9505.3650;

B. assure a CAC service, other than respite care, is not provided to a recipient while the recipient is an inpatient as defined in part 9505.0175, subpart 17; and

C. monitor providers of CAC services using the criteria in part 9505.3650.

9505.3650 PROVIDERS OF CAC SERVICES.

Subpart 1. **Criteria for selecting a CAC provider.** A provider of home and community-based services under CAC must meet the criteria in items A to C.

A. The provider must be employed by the county or have agreed as specified in subpart 2 to provide home and community-based services under CAC.

B. The provider must meet all licensure requirements

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and professional standards applicable to the service or services being provided as specified in parts 9505.3500 to 9505.3700.

C. The provider must not be a primary caregiver or responsible relative of the recipient to whom the provider is furnishing the home and community-based service.

Subp. 2. **Agreement to provide CAC services.** A lead agency may provide a CAC service directly or indirectly. If the lead agency chooses to provide the CAC service indirectly, the agency must have a contract, purchase agreement, or service agreement with the CAC service provider that specified the information in items A to I:

A. the beginning and ending dates of the contract or agreement;

B. the duties and responsibilities of the provider including compliance with applicable certifications, licensures, standards, and supervision of employees as required under parts 9505.3500 to 9505.3700;

C. the person or persons to be served as specified in the recipient's care plan;

D. an agreement to provide the service according to the amount, frequency, and scope specified in the care plan of the person being served;

E. the payment amount to be received for the service and the provider's agreement to accept this amount as payment in full;

F. the reports and records to be kept by the provider and given to the lead agency;

G. the provider's agreement to comply with the Minnesota Government Data Practices Act;

H. the provider's documentation of an individual abuse prevention plan that complies with parts 9555.8000 to 9555.8500; and

I. the conditions under which the lead agency shall terminate the provider's contract or agreement.

9505.3660 CAC PROVIDER RECORDS.

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The lead agency and a CAC provider under contract with the lead agency must maintain for at least five years complete program and fiscal records and supporting documentation identifying the 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 provider's records are subject to the maintenance schedule, audit availability requirements, and other provisions in parts 9505.1750 to 9505.2150.

9505.3670 RATES FOR CAC SERVICES.

Subpart 1. **Maximum CAC service rate.** Unless otherwise specified by the legislature, the commissioner shall annually set the maximum rate that is available to a county as reimbursement to a provider for a CAC service. The rates for CAC services must be consistent with medical assistance rates for comparable services. Annually on July 1 after the effective date of parts 9505.3500 to 9505.3700, the commissioner shall authorize an increase in the CAC service rates available to a county as reimbursement to a CAC provider up to the percentage change forecast by the Home Health Agency Market Basket. The Home Health Agency Market Basket is published by Data Resources and is subject to quarterly revision. The Home Health Agency Market Basket is incorporated by reference and is available through the Minitex interlibrary loan system.

Subp. 2. **Notice to counties.** By June 1 of each year, the commissioner shall notify a lead agency of the statewide maximum rate allowed for payment of providing CAC services under subpart 1. Additionally, the commissioner shall notify the counties in writing of the percentage increase allowed under subpart 1.

Subp. 3. **County CAC service rate.** A county may set rates for CAC services not to exceed the rates established in subpart 1. Under no circumstances is the department responsible for payment of rates higher than those established under subpart 1 and any amounts paid in excess of those rates shall be recoverable by the commissioner. County rates are subject to

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audit by the commissioner.

9505.3680 DEPARTMENT RESPONSIBILITIES.

Subpart 1. **Review and approval of CAC applications.** The commissioner must review and approve or deny each request for eligibility for the community alternative care program according to the criteria of part 9505.3520. The commissioner must determine whether the applicant is eligible for home and community-based services under CAC. No later than 15 working days after receiving the information required under part 9505.3540 to determine the applicant's eligibility for CAC, the commissioner must notify the acting case manager and the lead agency of its determination or of the additional information needed to make the determination.

Subp. 2. **Review of care plan and eligibility reassessments.** The commissioner must approve or deny care plan and eligibility reassessment recommendations according to the criteria of part 9505.3520. The recipient's preexisting care plan shall remain in effect pending the commissioner's approval or denial of the reassessment recommendation.

Subp. 3. **Records.** The department must maintain records related to the community alternative care program for a period of at least five years.

Subp. 4. **Monitor program expenses.** The department must monitor CAC expenditures to assure that the expenditures do not exceed the approved waiver limits for the home and community-based services under CAC.

9505.3690 BILLING FOR CAC SERVICES.

A CAC provider must submit a claim for payment for a CAC service specified in a recipient's care plan in the manner specified by the commissioner. A claim under this part must not exceed the amount specified in the contract, purchase agreement, or service agreement between the CAC provider and the lead agency. The CAC 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.

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9505.3700 APPEALS.

Subpart 1. **Appealable actions.** An applicant assessed under part 9505.3540 or a recipient reassessed under part 9505.3545 may appeal if one of the following actions is taken by the department or the local or lead agency:

A. a CAC service is denied;

B. eligibility for CAC services is not determined with reasonable promptness; or

C. a recipient's CAC services are reduced, suspended, or terminated.

Subp. 2. **Actions that are not appealable.** A denial, reduction, suspension, or termination of CAC services is not an appealable action if one of the following conditions applies:

A. the cost of the applicant's or recipient's home and community-based care exceeds the cost of hospital care;

B. the waiver aggregate average cost would be exceeded;

C. there are no openings available in the program; or

D. the case manager withdraws the CAC service or services as provided under part 9505.3560, subpart 6.

Subp. 3. **Notice of right to appeal.** An applicant assessed under part 9505.3540 or a recipient reassessed under part 9505.3545 has the right to appeal an action described in subpart 1. At the time a requested service is denied, reduced, suspended, or terminated by the case manager, lead agency, or department, the case manager must review with and provide the individual written notice about the proposed action and about the right to appeal. The notice must state the reasons for an appealable action, and an explanation of the right to appeal and how to appeal. The notice must also state that the recipient's ongoing CAC services will not be reduced, suspended, or terminated if the appeal is filed before the date specified in the notice, unless the recipient requests in writing not to receive CAC services while the appeal is pending.

Subp. 4. **Submission of appeals.** An applicant assessed

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under part 9505.3540 or a recipient reassessed under part 9505.3545 who wants to appeal must submit the appeal in writing to the local agency of the county of service or to the department. The appeal must be received by the department no later than 30 days after the recipient is made aware of the action taken in subpart 1 or no later than 90 days after the recipient is made aware of the action taken in subpart 1 if good cause reason for delay can be shown.

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

Subp. 6. **Continuation of services pending an appeal.** If a recipient appeals a denial, reduction, suspension, or termination of CAC services that the recipient has been receiving on an ongoing basis and that are part of the recipient's care plan approved by the recipient's physician, the lead agency must continue to provide the ongoing CAC services at the level specified in the recipient's care plan until a decision on the appeal is recommended by the department's referee and adopted by the commissioner. Nothing in parts 9505.3500 to 9505.3700 shall prohibit the department from seeking reimbursement from the recipient for the costs of providing CAC services pending a decision on an appeal if the order adopted by the commissioner is adverse to the recipient.

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APPROVED AS TO FORM AND LEGALITY

December 11 1990

HUBERT H. HUMPHREY, III
ATTORNEY GENERAL

BY MJ Cassedy

SPECIAL ASSISTANT ATTORNEY GENERAL

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED

DEC 11 1990 4:20 PM

Joan Anderson Growe

Secretary of State

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
Human Services Building
444 Lafayette Road
St. Paul, Minnesota 55155-38__

4-27-90

TO: Patricia Nolte, Legal Assistant
Public Finance Division
404 Capitol Office Building
525 Park Street

FROM: Eleanor Weber

SUBJECT: Review of a Rule Adopted Without a Public Hearing: Community Alternative Care Program, Minnesota Rules, parts 9505.3500 to 9505.3700

Enclosed are the documents required to be submitted under Minnesota Rules, part 2010.033 for your review of a rule adopted without a public hearing for the above entitled matter.

Official documents in this submitted material include:

1. A copy or photocopy of the notice of solicitation of outside information or opinions as published in the State Register.

2. A copy of the proposed rule with a certificate of approval as to form by the revisor of statutes attached.

3. The notice of intent to adopt a rule without a public hearing as mailed.

4. The statement of need and reasonableness in support of the proposed rule complying with part 2010.0700.

5. The affidavit of mailing the notice of intent to adopt a rule without a public hearing. The affidavit states that the mailing list maintained by the agency pursuant to Minnesota Statutes, sections 14.22 and 14.14, subdivision 1a is accurate, complete, and current and that the notice of intent to adopt the rule without a public hearing was mailed to all persons and groups whose names appear on the list.

6. A copy or photocopy of the notice of intent to adopt the rule without a public hearing as published in the State Register.

7. Four copies of the rule as adopted. Any modification made to the proposed rule is reflected on the rule as adopted and is approved as to form by the revisor of statutes.

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8. The findings of fact, conclusions, and order adopting the rule.

9. All written requests, submissions, or comments on the rule received by the agency except requests solely for copies of the rule or of the statement of need and reasonableness.

10. The declaration of the attorney in the attorney general's office who represents the agency.

11. The notice of submission of the rule to the attorney general, if applicable.

12. The affidavit of mailing notice of submission of the rule to the attorney general, if applicable.

If you have any questions on this submitted material, please call me at 297-4301.

Department of Human Services

Health Care and Residential Programs Division

Notice of Solicitation of Outside Information or Opinions Regarding Proposed Permanent Rules Governing Community Alternative Care for Chronically Ill Individuals Under Age 65 Who Would Otherwise Reside in Acute Care Facilities

Notice is hereby given that the State Department of Human Services is seeking information or opinions from sources outside the agency in preparing to propose adoption of a permanent rule governing community alternative care for chronically ill individuals under age 65 who would otherwise reside in an acute care facility. The adoption of the rule is authorized by *Minnesota Statutes*, section 256B.49, subdivision 2, which permits the commissioner to adopt permanent rules as necessary to implement section 256B.49, subdivision 1, authorizing the application for federal waivers necessary to obtain federal financial participation for the costs of home and community-based services.

The State Department of Human Services requests information and opinions concerning the subject matter of the rule. Interested persons or groups may submit data or views on the subject matter of concern in writing or orally. Written statements should be addressed to:

Phyllis Zwieg
Long Term Care Management
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3831

Oral statements will be received during regular business hours over the telephone at (612) 296-2916, and in person at the above address.

All statements of information and opinions shall be accepted until further notice is published in the *State Register* or the Notice of Hearing or Notice of Intent to Adopt Rules Without a Hearing is published in the *State Register*. Any written material received by the State Department of Human Services shall become part of the rulemaking record to be submitted to the attorney general or administrative law judge in the event that the rule is adopted.

Department of Human Services

Health Care Programs Division

Notice of Solicitation of Outside Information or Opinions Regarding Proposed Amendments to Rules Governing Hospital Medical Assistance Reimbursement

Notice is hereby given that the State Department of Human Services is seeking information or opinions from sources outside the agency in preparing to propose amendments to the rules governing the readmission and reimbursement for readmissions, *Minnesota Rules*, parts 9500.1100 subpart 42, and 9500.1130 subpart 8.

The adoption of the rule is authorized by *Minnesota Statutes*, section 256.969, subdivision 6, which requires the agency to promulgate permanent rules to implement a system of prospective payment for inpatient hospital services.

The proposed amendments establish procedures to coordinate the medical assistance reimbursement for readmissions with the required procedures for obtaining hospital admission certification as set forth in *Minnesota Rules*, parts 9505.0500 to 9505.0540. (*Minnesota Rules*, parts 9505.0500 to 9505.0540 are being amended concurrently with the amendments to *Minnesota Rules*, parts 9500.1100 subpart 42 and 9500.1130 subpart 8).

The State Department of Human Services requests information and opinions concerning the subject matter of the rule. Interested persons or groups may submit data or views on the subject matter of concern in writing or orally. Written statements should be addressed to:

Anupama Seam
Rules Division
Minnesota Department of Human Services
444 Lafayette Rd. 2nd Floor South
St. Paul, MN 55101-3816

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ADMINISTRATIVE
HEARINGS

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Adoption of Rules of the State Department of Human Services Relating to Community Alternative Care Program, Minnesota Rules, Parts 9505.3500 to 9505.3700

FINDINGS OF FACT, CONCLUSIONS, AND ORDER ADOPTING RULE WITHOUT PUBLIC HEARING

(1) Notice of the Commissioner's intent to adopt the above-entitled rule was published in the State Register on Monday, August 20, 1990 and was sent by United States mail to all persons on the list maintained by the agency pursuant to Minnesota Statutes, sections 14.14, subdivision 1a and 14.22 on August 15, 1990.

(2) The statement of need and reasonableness was prepared before the notice of intent to adopt a rule without a public hearing was mailed to all persons on the rulemaking mailing list and published in the State Register and was available to the public.

(4) All persons were given the opportunity to submit comment on the rule for 30 days after notice of proposed rulemaking. (5) Two requests for a public hearing on the rule were received by the agency. Therefore the agency did not receive requests for a public hearing from 25 or more persons which were not withdrawn. No requests for notice of submission to the attorney general were received by the agency.

Based on the comments and evidence in the record before the agency, I find the following:

(6) **1. 9505.3510, subpart 7, Case manager. page 2, lines 31 to 34.**

Ms. Patricia Puetz, Executive Director, State of Minnesota Board of Social Work, commented that "Social Work Case Managers employed by a County (lead agency) are not required to be licensed and are therefore exempt from licensure requirements as set forth in Minnesota Statutes, sections 148B.21 - 148B.23" but that "Social Work Case Managers employed by another agency are required to be licensed by the Board of Social Work."

The department thanks Ms. Puetz for her comment about licensure of social workers. The issue of the licensure of social workers is addressed in Finding 3 about part 9505.3510, subpart 31 and in Finding 9 about part 9505.3510, subpart 49.

2. Part 9505.3510, subpart 10a, page 3, lines 17 to 24.

Ms. Anita Boucher, Program Development Specialist, Courage Center, suggested "listing group counseling (both psychotherapy and support groups) [sic] as a service that may be approved by the case manager."

The department has considered Ms. Boucher's suggestions. The focus of counseling and training provided under the waiver is to assist the primary caregiver and other members of the recipient's family by reducing stress and providing coping strategies so that the recipient can be maintained at home. Group counseling would be approved as part of the care plan if the group counseling is related to maintaining the recipient at home. The services under the waiver are not directed to psychotherapy. See the definition of psychotherapy in part 9505.0323, subpart 1, item T which defines psychotherapy as a treatment "...based on a diagnosis of mental illness resulting from a diagnostic assessment...." If the recipient or a member of the recipient's family who also is eligible for medical assistance services is diagnosed as mentally ill, the person would be eligible for mental health services under part 9505.0323. The department believes it would be limiting, and therefore, unreasonable to list all the services related to family counseling and mental health that might be medically

necessary and appropriate for a recipient and the recipient's primary caregiver or family members. Therefore, the department declines Ms. Boucher's request to modify the rule.

Ms. Boucher also requested revision of this subpart to include the phrase "or other adaptive equipment."

The department finds that certain items of adaptive equipment that may not be specifically health related may be necessary to safely maintain a recipient at home and avoid institutionalization. Such items include environmental controls or switches designed to replace the function of a body part. For example, adaptive equipment includes devices that enable a person to open a door or to start or stop electrical devices when the person is physically unable to do so in any other manner. The recipient's need for such adaptive equipment would be determined by the appropriate health care professional and specified in the recipient's approved care plan. Therefore, the department modifies the rule as follows:

page 3, line 24, after "medical equipment", insert "<u>or other adaptive equipment necessary to avoid institutionalization</u>"

The department finds the modification is not substantial but only for purposes of clarification.

3. 9505.3510, subpart 31, Medical social worker. page 16, lines 8 to 12.

Ms. Boucher suggested modifying this definition and requiring a medical social worker be licensed. Ms. Puetz commented, "Currently Social Workers employed by a hospital facility are not required to be licensed.....However, other situations indicated in this section may require licensure by the Board of Social Work."

The department has considered the comments of Ms. Boucher and Ms. Puetz and also reviewed the waiver definition. The medical social worker who is part of the interdisciplinary team required under part 9505.3535, subpart 1 is designated as a team member by the hospital from which the recipient is being discharged. Hospitals employ medical social workers to assist in discharge planning. It is reasonable to expect that the medical social worker designated by the hospital as a team member in most instances will be an employee of the hospital. Minnesota Statutes, section 148B.28, subdivision 6 states that the "licensure of social workers employed by hospitals .... shall be voluntary. Hospitals...employing social workers shall not be required to employ licensed social workers, nor shall they require their social work employees to be licensed." In the event the medical social worker is not an employee of the hospital or of a governmental agency such as the county and, therefore, must be licensed, the person serving as a medical social worker is responsible for complying with the requirements established by the Board of Social Work under Minnesota Statutes, sections 148B.21 to 148B.28. (See Minnesota Statutes, section 148B.27 which prohibits unlicensed social work practice and establishes a violation of the licensure requirement as a misdemeanor.) Therefore, the department finds it is not necessary to clarify the definition and declines the

request to modify the definition.

4. 9505.3510, subpart 34, Nursing services. page 6, lines 18 to 22.

Ms. Susan Stout, Staff Specialist, Governmental Affairs, Minnesota Nurses Association, suggested that the definition of nursing services be revised to "recognize that the RN practices under the entire scope of nursing practice as defined under the Nurse Practice Act and the Licensed Practical Nurse functions under a very limited scope which does not include the supervision of paraprofessionals." Ms. Stout suggested a modification.

The department has reviewed proposed subpart 34 in light of Ms. Stout's comment. The intent of the definition is to recognize that there are three ways to perform the professional nursing services ordered by a physician and specified in a plan of care: 1)as an independent nursing function of a registered nurse under Minnesota Statutes, section 148.171 (3); 2) as a practical nursing function of a licensed practical nurse under Minnesota Statutes, section 148.29; or 3) by the delegation of the registered nurse to other nursing personnel who work under the supervision of a registered nurse according to Minnesota Statutes, section 148.271 (3) and (5). The department believes that the language of the definition clearly reflects the statutes cited in the preceding sentence. Therefore, the department finds that further clarification is not necessary and declines Ms. Stout's request to modify the rule. See the definition of licensed practical nurse in subpart 28 of part 9505.3510 and the definition of registered nurse in subpart 45 of part 9505.3510.

5. Part 9505.3510, subpart 36, Occupational therapist., page 6, lines 27 to 35.

Ms. Karen Sames, President, Minnesota Occupational Therapy Association, wrote that registration of occupational therapists is a function of the American Occupational Certification Board.

The department thanks Ms. Sames for her clarification and modifies the rule as follows:

page 6. line 33, delete "Therapy Association" and insert "Certification Board"

The department finds the modification is not substantial but only for technical purposes.

6. Part 9505.3510, subpart 37, Physical therapist. page 6, line 37 and page 7, lines 1 and 2.

Ms. Boucher suggested revising the definition to require that the person be licensed or eligible to be licensed by the state of Minnesota as a physical therapist.

Minnesota Statutes, section 148.71, requires a physical therapist to qualify by obtaining a certificate of registration from the Board of Medical Examiners. The definition is consistent with the statutory requirement. Furthermore, Minnesota Statutes, section 148.72 provides reciprocity and issuance of registration to physical therapists licensed or registered by certain other states and the District of Columbia. Therefore, the department finds the definition is consistent with Minnesota Statutes and a modification is not necessary.

7. Part 9505.3510, subpart 39, Prescribed Drug. page 7 lines 6 to 9.

Ms. Stout suggested revising the definition to "a drug defined in Minnesota Statutes, section 151.01, subdivision 5, ordered by a health care provider with legal authority to write prescriptions in Minnesota and specified in the recipients (sic) care plan." She based her suggestion on the statutory authorization of certified nurse practitioners, certified nurse midwives, and physician assistants to write prescriptions as delegated by a physician.

The department has reviewed the statutes and laws cited by Ms. Stout. The department has also reviewed the waiver which requires a prescribed drug to be "subject to prior authorization by the attending physician as evidenced in the patient care plan." The department believes the waiver permits a person to prescribe drugs if the person has the legal authority to write prescriptions as delegated by a physician. Therefore, the department finds it necessary to clarify the rule as follows:

page 7, line 8, strike "~~ordered~~" and insert "authorized"

The department finds the modification is not substantial but only for purpsoes of clarification.

8. Part 9505.3510, subpart 42, Public Health Nurse. page 7, lines 22 to 25.

Ms. Stout commented that the agency with the authority to certify public health

nurses is the Minnesota Board of Nursing.

The department thanks Ms. Stout for her comment. As stated above, the waiver requires persons providing services under the CAC program to meet all applicable state licensure and certification requirements. Minnesota Statutes 1989, section 148.171, defines a "public health nurse" as a registered nurse who meets the voluntary registration requirements established by the board by rule." Minnesota Statutes 1989, section 148.232 grandfathers public health nurses who were certified as public health nurses by the commissioner of health before the 1989 statutory amendments. The department finds it necessary to modify the rule to be consistent with Minnesota Statutes, section 148.171 and modifies the rule as follows:

page 7, lines 23 to 25, "means a registered nurse ~~certified by the Minnesota Department of Health as a public health nurse under Minnesota Statutes, section 145A.02, subdivision 18~~ who meets the requirements of Minnesota Statutes, section 148.232 or the voluntary registration requirements established by the Minnesota Board of Nursing under Minnesota Statutes, section 148.171, paragraph (8).

The department finds the modification is not substantial but is only for purposes of clarification.

9. Part 9505.3510, subpart 49, Social Worker. page 8, lines 21 to 25.

Ms. Boucher suggested "re-labeling this subpart as 'County Social Worker' to further distinguish the duties of county social workers from those of social workers who may be involved in providing counseling services." Ms. Puetz commented that social workers employed by a county or the state are not required to be licensed but that licensure is required for other social workers practicing within the scope of Minnesota Statutes, sections 148B.21 to 148B.23. See also Finding 1.

The department has carefully considered the comments of Ms. Boucher and Ms. Puetz and has reviewed the statutes cited by Ms. Puetz. Proposed parts 9505.3500 to 9505.3700 use the terms social worker, county social worker, and medical social worker. Part 9505.3510, subpart 49 requires social workers to be employed by the county. The term "county social worker" is not defined in parts 9505.3500 to 9505.3700. However, the term as defined in Minnesota Statutes, section 148B.18, subdivision 4, means "an individual who is employed by a county social service agency in Minnesota in social work practice or clinical social work." Thus the term "social worker" as defined in subpart 49 is consistent with the statutorily defined term "county social worker". See also Minnesota Statutes, section 148B.28, subdivision 4 which states that the licensure of social workers employed by a county shall be voluntary, that counties employing social workers shall not required to employ licensed social workers, and that counties shall not require their social workers to be licensed. Thus Minnesota Statutes, sections 148B.18 to 148B.28 do not specify the requirements to qualify as a county social worker. However, the waiver approving the community alternative care program does specify the qualifications that a county social worker must have in order to provide CAC services. See Waiver Attachment III, Qualifications of Providers

of Waivered Services. Subpart 49 includes the waivered-required professional qualifications as well as the requirement of county employment. The department believes that rule's use of the term "social worker" is reasonable because it is consistent with the statutory requirement of county employment. However, because it includes requirements not found in the statute, the use of a term different from the statutory term avoids possible confusion.

The department has reviewed the use of the terms "social worker" and "county social worker" in parts 9505.3500 to 9505.3700. The term "county social worker" is used in four places: part 9505.3510, subpart 2; part 9505.3535, subpart 1, item F; part 9505.3535, subpart 2, item E; and part 9505.3600, subpart 5. Therefore, the department finds it necessary and reasonable to clarify the rule as follows:

page 2, line 8, ~~county~~ social worker, or registered nurse who is appointed by

page 11, lines 26 and 27, F. the ~~county~~ social worker designated under part 9505.3530, subpart 3;

page 12, lines 17 and 18, E. the ~~county~~ social worker designated under part 9505.3530, subpart 3;

page 23, line 13, health nurse, a ~~county~~ social worker, or a medical social

The department finds the modifications are not substantial but only for purposes of clarification.

10. Part 9505.3520, item D, page 9, lines 25 to 30.

Mr. Todd Monson, CAC Program Manager, Hennepin County Community Health

Department, wrote "in order for a CAC care plan to work, the case manager must determine that the primary caregiver is capable; so I am requesting that the phrase 'by a health care professional' be changed to 'the county case manager'." The department agrees that it is necessary to clarify the relation between the recipient's case manager and the recipient's primary caregiver. The case manager has certain responsibilities related to the recipient's care including assuring the recipient's safety and welfare and implementation of the recipient's services as specified in the recipient's care plan. See part 9505.3560, subparts 3 to 6. The primary caregiver also has responsibilities for the recipient's care. See part 9505.3525, subpart 40. Therefore, department modifies the rule as follows:

page 9, line 26, insert after "professional", the phrase "in coordination with the case manager"

The department finds the modification is not substantial but only for purposes of clarification.

11. Part 9505.3624 , subpart 1. page 25, line 12.

As stated above in finding 7, Ms. Stout requested modification of provisions related to prescribed drugs to ensure consistency with Minnesota Statutes authorizing certain individuals to write prescriptions. Ms. Stout also requested modification of the definition of health care professional (part 9505.3510, subpart 17) or deletion of licensed practical nurse from the definition of health care professional.

The department finds it necessary to modify subpart 1 of part 9505.3624 to achieve the required consistency with statutes establishing authority to prscribe drugs and modifies the rule as follows:

page 25, line 12, insert "authorized" in place of " prescribed"

The department finds the modification is not substantial but only for the purposes of clarification.

The department has also reviewed the definition of health care professional. The definition is intended to include all persons licensed, certified, or registered and eligible to provide CAC services under parts 9505.3500 to 9505.3700. It should be noted that the term "health care provider" suggested by Ms. Stout has a meaning different from that of health care professional and applies to persons under contract to the lead agency who may or may not themselves furnish the service directly to the recipient. The department declines Ms. Stout's suggestion.

12. Page 13, line 19; Page 14, lines 11 to 15; Page 14, line 30; Page 19, lines 24 to 29

Mr. Monson commented that provisions at these locations require the counties to use mandated DHS forms and requested that "the rule clearly state that the counties must use the forms as designated by the commissioner as....in subp 5 p.13, lines 18-19."

The department has reviewed all of the provisions cited by Mr. Monson and finds

that the language is not the same in all instances but that the rule's intent is the same. Therefore the department finds it necessary to clarify the rule and modifies the rule as follows:

page 13, line 19, delete "supplied", insert "provided"

page 14, lines 13, delete "supplied", insert "provided"

page 19, line 31, insert before "An applicant...", "The information required in items N, O, and Q must be provided on forms provided by the commissioner."

The department finds the modifications are only for clarification and for technical purposes.

13. Part 9505.3580, subpart 2, item B. page 22, lines 2 to 6.

Mr. Monson requested that the rule be clarified to require a primary caregiver to designate a person who can make decision's about the recipient's home in an emergency taking place during the primary caregiver's period of respite.

The department has considered Mr. Monson's request and finds it is necessary to clarify the extent of the authority of a nurse providing respite care in the recipient's home. However, the department finds that such a requirement properly belongs in subpart 3 which sets requirements about a contract for respite care as the lead agency is responsible to take the necessary safeguards to protect the health and welfare of the recipient. See part 9505.3645, subpart4. The department modifies subpart 3 as follows:

page 22, line 11, insert after the ".", "Additionally, the contract must include the authority of the person providing the respite care to act in the event of an emergency affecting the recipient or the recipient's home or must include the

name of the person designated by the primary caregiver to act on behalf of the primary caregiver in the event of such an emergency.

The department finds the modification is not substantial but only for purposes of clarification.

14. Part 9505.3620, subpart 2, item C; page 24, line 24.

Mr. Monson requested deletion of the figure of $25.

The figure of $25 is specified in the waiver. To revise or remove the amount would require the department to request HCFA's approval of an amendment of the waiver. The department does not want to submit a request for a waiver amendment at this time as such a request might open the door to federally required amendments. Therefore, the department declines to accept Mr. Monson's request to change the rule.

15. 9505.3640, subpart 3, Calculation of parental or spousal contribution. page 27, lines 30 to 35 and page 28, lines 1 to 8.

Mr. Monson commented that "[i]t would be most effective/least confusing if DHS handled all contributions, including these, and not require the county attorneys to get involved."

The department has very carefully considered Mr. Monson's comment and agrees that one method of handling contributions required of recipients' responsible relatives regardless of the program providing the recipients' services would be least confusing and most effective.

The eligibility of a child to receive home and community based services through

CAC is determined without regard to the income and assets of the child's parents. Minnesota Statutes, section 256B.14 1990, subdivision 2 requires the parents to contribute partial or complete payment or repayment for the services received by a child under a federal medical assistance waiver. The amount of the payment is determined according to Minnesota Statutes 1990, section 252,27, subdivision 2a. At present notices about the amount of the parental contribution are sent by the department if the child resides with the parent or parents and are sent by the county agency if the child resides in a foster care home. This system evolved from two responsible relative payment determination and billing procedures in long standing use by the department. Under Minnesota Statutes, section 246.51 the department has determined the ability of responsible relatives to pay part or all of the cost of care of a child who resides in a regional treatment center and has billed the responsible relatives. On the other hand, counties have been responsible for determining, according to appropriate rule and statute, and billing the contribution required of responsible relatives of children who are in 24 hour care outside of the home. The department at present is discussing the advisability of having one agency, the department, be responsible for all determinations of and billings for parental contributions, the actions necessary to carry out this change, and its timing. Such a centralized system would be administratively efficient and would assure statewide equity. To allow flexibility to implement the decision without at the same time necessitating a rule amendment, the department finds it necessary to modify the rule as follows:

page 27, lines 30 to 35 and page 28, lines 1 to 8: **Calculation of parental or spousal contribution.** ~~The local agency must determine the financial~~

~~contribution to be made by a recipient's parent or spouse, as appropriate, for services to the recipient.~~ The financial contribution of a parent or spouse shall be determined according to Minnesota Statutes, sections 256B.14 and 252.27, and appropriate rules adopted under those statutes. The refusal or failure of a recipient's obligated parent or spouse to pay the contribution does not affect the recipient's eligibility for medical assistance and CAC.

If the department or the local agency finds that the obligated parent or spouse refused or failed to pay the determined contribution, a cause of action exists against the obligated parent or spouse and a civil action against the obligated parent or spouse may be initiated as authorized in Minnesota Statutes, sections 256B.14 and 252.27. ~~The local agency of the recipient's county of financial responsiblity shall refer the refusal or failure to pay to the county attorney for action to enforce payment of the contribution~~.

The department finds the modification is not substantial but only for purposes of clarification.

CONCLUSIONS

I hereby conclude that:

1. All modifications made to the proposed rule are not substantial chnages.

2. The rules, as modified, are necessary and reasonable.

3. Any duplication in these rules of language contained in Minnesota Statutes is crucial to the ability of persons affected by the rules to comprehend their meaning.

4. The department has complied with all applicable provisions of law and rule in the promulgation of these rules.

5. If any finding or part of a finding, above, is properly characterized as a

conclusion, it is adopted as a conclusion.

NOW, THEREFORE, IT IS ORDERED that the rules identified as Minnesota Rules, parts 9505.3500 to 9505.3700 are adopted this 26th day of November, 1990, pursuant to authority vested in me by Minnesota Statutes, section 256B.49, subdivision 2.

ANN WYNIA

COMMISSIONER OF HUMAN SERVICES

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HEARINGS

Department of Human Services

Proposed Permanent Rules Relating to Community Alternative Care Program

Rules as Proposed (all new material)

COMMUNITY ALTERNATIVE CARE PROGRAM

9505.3500 APPLICABILITY AND EFFECT.

Subpart 1. **Applicability.** Parts 9505.3500 to 9505.3700 establish standards and procedures applicable to the community alternative care (CAC) program. Individuals who are eligible for and receiving medical assistance services may also be eligible for and receive services under the community alternative care program. CAC pays for approved home and community-based services in lieu of hospital admission or continued hospitalization for individuals who meet the requirements of parts 9505.3500 to 9505.3700, Minnesota Statutes, section 256B.49, and the Code of Federal Regulations, title 42, section 441.302(e)(2). Parts 9505.3500 to 9505.3700 must be read in conjunction with Minnesota Statutes, chapter 256B; parts 9500.1070, subparts 1 and 12 to 15; 9500.1090 to 9500.1155; chapter 9505; Title XIX of the Social Security Act; and title 42 of the Code of Federal Regulations; and the requirements of the waiver obtained by the state from the United States Department of Health and Human Services.

Parts 9505.3500 to 9505.3700 apply to local agencies administering medical assistance funds and providing case management services; entities and organizations contracting to perform functions under Minnesota Statutes, 256B.49; providers of home and community-based services who are paid or who request payment under parts 9505.3500 to 9505.3700; and CAC applicants and recipients.

Subp. 2. **Effect.** References to the waiver and waiver provisions that occur in parts 9505.3500 to 9505.3700 shall continue in effect only as long as the waiver from the United

Approved by Revisor KTN

States Department of Health and Human Services is in effect in Minnesota.

9505.3510 DEFINITIONS.

Subpart 1. **Applicability.** The definitions in this part apply to parts 9505.3500 to 9505.3700.

Subp. 2. **Acting case manager.** "Acting case manager" means a person who is a public health nurse, medical social worker, county social worker, or registered nurse who is appointed by the department and performs case management services specified in subpart 6 for an applicant until the applicant's eligibility for CAC services is determined and a case manager is assigned.

Subp. 3. **Applicant.** "Applicant" means an individual who has submitted an application to participate in the CAC program rather than reside in a hospital or remain at risk of frequent hospitalization.

Subp. 4. **Application.** "Application" means an application to participate in CAC that is completed according to part 9505.3540.

Subp. 5. **Assessment.** "Assessment" means the process an interdisciplinary team uses to identify an applicant's health service needs according to part 9505.3540 so that the team can determine the appropriateness of home and community-based services in meeting the applicant's needs.

Subp. 6. **Case management services.** "Case management services" means services in which a case manager identifies, arranges, authorizes, and coordinates health services including home and community-based services under parts 9505.3500 to 9505.3700 for a recipient; monitors the delivery of services; adjusts services to the needs of the recipient; and advocates for the rights of the recipient.

Subp. 7. **Case manager.** "Case manager" means a social worker, registered nurse, or public health nurse who is employed by or under contract with the lead agency and who performs case management services.

Subp. 8. **Chronically ill individual or individual.**

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"Chronically ill individual" or "individual" means an individual who needs an extensive array of health services for an undetermined period of time, whose health condition requires frequent monitoring and treatment by a health care professional or by a person supervised by a health care professional, and who would reside in a hospital or require frequent hospitalization if these services were not provided.

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

Subp. 10. **Community alternative care program or CAC.** "Community alternative care program" or "CAC" means the program specified in the Minnesota Medicaid model waiver approved by the United States Department of Health and Human Services to provide home and community-based services to chronically ill individuals under age 65.

Subp. 10a. **Counseling and training services.** "Counseling and training services" means counseling and training approved by the case manager for primary caregivers in issues pertaining to the maintenance of the recipient in the home. Examples of counseling are crisis counseling and family or individual counseling as required for family functioning. An example of training is teaching a family member or other primary caregiver a treatment regimen or how to use medical equipment.

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 that performs or arranges services for recipients under parts 9505.3500 to 9505.3700. County of service may be either the county of financial responsibility or the county in which the recipient resides.

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

Subp. 14. **Durable medical equipment.** "Durable medical equipment" means a device that can withstand repeated use, is

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provided to correct or accommodate a physiological disorder or physical condition, and is suitable for use in the recipient's residence.

Subp. 15. **Environmental modifications in the home.** "Environmental modifications to the home" means structural changes to a recipient's residence that are prescribed in the recipient's care plan and that are necessary to maintain the recipient in the recipient's home. Examples of environmental modifications are changes in electrical wiring to accommodate equipment, construction of wheelchair ramps, and widening of doors.

Subp. 16. **Foster care services.** "Foster care services" means ongoing residential care and supportive services provided to a recipient living in a foster home licensed under parts 9545.0010 to 9545.0260; or 9555.5105 to 9555.6265.

Subp. 17. **Health care professional.** "Health care professional" means a physician, registered nurse, licensed practical nurse, occupational therapist, physical therapist, respiratory therapist, or a speech-language pathologist.

Subp. 18. **Health service.** "Health service" means a medically necessary service that is ordered by a physician, documented in an approved care plan, and provided to a recipient as ordered in the care plan. The term includes home and community-based services and services provided under parts 9505.0170 to 9505.0475.

Subp. 19. **Home.** "Home" means the recipient's residence as defined in part 9505.0175, subpart 43. "Home" does not include a hospital or long-term care facility.

Subp. 20. **Home and community-based services.** "Home and community-based services" means the services listed in items A to L that are available under the waiver to recipients:

A. case management services under part 9505.3560;

B. home health services under part 9505.3570;

C. homemaker services under part 9505.3575;

D. respite care services under part 9505.3580;

E. physician services under part 9505.3585;

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F. family counseling and training under part 9505.3600;

G. environmental modifications in the home under part 9505.3610;

H. medical equipment under part 9505.3620;

I. medical transportation under part 9505.3622;

J. prescribed drugs under part 9505.3624;

K. other professional services under part 9505.3626; and

L. foster care services under part 9505.3630.

Subp. 21. **Home care plan or care plan.** "Home care plan" or "care plan" means the written plan of health services provided to a recipient that are necessary to maintain a recipient in the recipient's home.

Subp. 22. **Home health aide.** "Home health aide" means a person who meets the standards for a home health aide in part 9505.0290, subpart 3.

Subp. 23. **Homemaker.** "Homemaker" means a person who provides homemaker services and is qualified according to part 9565.1200, subpart 2.

Subp. 24. **Homemaker services.** "Homemaker services" means the activities specified in parts 9565.1100 and 9565.1200 that are prescribed in the recipient's care plan and provided by a homemaker.

Subp. 25. **Hospital.** "Hospital" has the meaning given in Minnesota Statutes, section 144.696, subdivision 3.

Subp. 26. **Interdisciplinary team or team.** "Interdisciplinary team" or "team" means a team specified in part 9505.3535 that is responsible for developing a home care plan for an applicant or for a recipient.

Subp. 27. **Lead agency.** "Lead agency" means the county welfare department or public health agency designated by the local agency to administer CAC.

Subp. 28. **Licensed practical nurse.** "Licensed practical nurse" means a person licensed under and providing health services within the scope of Minnesota Statutes, section 148.29.

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Subp. 29. **Local agency.** "Local agency" means the county or multicounty agency that is authorized under Minnesota Statutes, section 256B.05 to administer the medical assistance program, including the community alternative care program.

Subp. 30. **Medical assistance.** "Medical assistance" means the program established under title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

Subp. 31. **Medical social worker.** "Medical social worker" means a graduate of a school of social work accredited by the Council on Social Work Education who has had social work experience in a hospital, outpatient clinic, medical rehabilitation, or medical care program.

Subp. 32. **Medically necessary.** "Medically necessary" has the meaning given in part 9505.0175, subpart 25.

Subp. 33. **Nondurable medical equipment.** "Nondurable medical equipment" means a supply or piece of equipment that is used to treat a health condition and that cannot be reused.

Subp. 34. **Nursing services.** "Nursing services" means services ordered by a physician, specified in the recipient's care plan, and provided by a licensed practical nurse or provided by a registered nurse or provided under the supervision of a registered nurse.

Subp. 35. **Nutritionist.** "Nutritionist" means a person who at a minimum has a bachelor's degree in nutrition and foods or a closely related field and is registered as a dietitian with the Commission of Dietetic Registration.

Subp. 36. **Occupational therapist.** "Occupational therapist" means a person who is currently registered as an occupational therapist with the American Occupational Therapy Association or who is a graduate of a program in occupational therapy approved by the Council of Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association and who is acquiring the supervised clinical experience prerequisite to registration by the American Occupational Therapy Association.

Subp. 37. **Physical therapist.** "Physical therapist" means

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a person holding a current Minnesota certificate of registration as a physical therapist.

Subp. 38. **Physician.** "Physician" means a person who is licensed to provide health services within the scope of the physician's profession under Minnesota Statutes, chapter 147.

Subp. 39. **Prescribed drug.** "Prescribed drug" means a drug as defined in Minnesota Statutes, section 151.01, subdivision 5, ordered by the recipient's physician, and specified in the recipient's care plan.

Subp. 40. **Primary caregiver.** "Primary caregiver" means the person designated by the individual as having the main role in providing informal care to the individual. Primary caregiver includes a family member, relative, friend, neighbor, and other person, who agrees to provide routine care and assistance to the recipient without reimbursement for the services and who cooperates with the case manager and other providers in assuring that services specified in the recipient's care plan are provided.

Subp. 41. **Provider.** "Provider" means a vendor who has an agreement or contract with the lead agency to provide a home and community-based service as specified in subpart 20.

Subp. 42. **Public health nurse.** "Public health nurse" means a registered nurse certified by the Minnesota Department of Health as a public health nurse under Minnesota Statutes, section 145A.02, subdivision 18.

Subp. 43. **Reassessment.** "Reassessment" means the interdisciplinary team's formal redetermination of a recipient's home and community-based service needs under part 9505.3545.

Subp. 44. **Recipient.** "Recipient" means an individual determined to be eligible to receive home and community-based services under a care plan that meets the requirements of part 9505.3520 and that is approved by the commissioner under part 9505.3680.

Subp. 45. **Registered nurse.** "Registered nurse" means a person licensed under and providing services within the scope of Minnesota Statutes, section 148.211.

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Subp. 46. **Representative.** "Representative" means a person appointed by a court as a guardian or conservator under Minnesota Statutes, sections 252A.01 to 252A.21, or 525.539 to 525.6198; a parent of a child under age 21 unless the parent's parental rights have been terminated; or a spouse or other person authorized by the applicant or recipient as defined in part 9505.0015, subpart 8.

Subp. 47. **Respiratory therapist.** "Respiratory therapist" means a person who is a graduate of a program in respiratory therapy approved by the Council of Medical Education of the American Medical Association in collaboration with the American Respiratory Therapy Association. If the legislature acts to require certification, registration, or licensure of respiratory therapists, "respiratory therapist" means a person certified, registered, or licensed as a respiratory therapist by the state of Minnesota.

Subp. 48. **Respite care services.** "Respite care services" means temporary supervision, assistance, and care provided to a recipient as specified in part 9505.3580 to relieve the recipient's primary caregiver, or other informal caregiver.

Subp. 49. **Social worker.** "Social worker" means an individual who meets the minimum qualifications of a social worker under the Minnesota Merit System or a county civil service system in Minnesota and who is employed as a social worker by a county.

Subp. 50. **Speech therapist or speech-language pathologist.** "Speech therapist" or "speech-language pathologist" means a person holding a current certificate from the American Speech-Language-Hearing Association in evaluation and treatment of speech-language pathologies or who has completed the academic requirements and is acquiring the supervised work experience required for certification.

Subp. 51. **Transportation.** "Transportation" means transportation that is necessary because of the recipient's health service needs, that is indicated in the recipient's care plan or is approved by the recipient's case manager, and that is

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not eligible for medical assistance payment under parts 9505.0010 to 9505.0475.

Subp. 52. **Waiver.** "Waiver" means the document approved by the United States Department of Health and Human Services that allows the state to exclude parental or spousal income when determining an applicant's eligibility for medical assistance and to extend services under medical assistance as specified in parts 9505.3500 to 9505.3700. The term includes all amendments to the waiver, including any amendments after the effective date of parts 9505.3500 to 9505.3700, as approved by the United States Department of Health and Human Services.

Subp. 53. **Waiver year.** "Waiver year" means April 1 to March 31.

Subp. 54. **Working day.** "Working day" means the hours of a day, excluding Saturdays, Sundays, and holidays, when a lead agency is open for business.

9505.3520 ELIGIBILITY FOR COMMUNITY ALTERNATIVE CARE SERVICES.

An individual is eligible for home and community-based services through CAC if the conditions in items A to I are met.

A. The individual is eligible for medical assistance as specified in part 9505.3640, subpart 1.

B. The individual is under 65 years of age.

C. The individual needs a home and community-based service which cannot be funded by sources other than CAC.

D. The individual has designated a primary caregiver who has been determined by a health care professional to be capable of providing specific health services to the individual in the individual's residence and has expressed a willingness to provide the specific health services according to the individual's care plan.

E. The primary physician has certified that the individual would reside in a hospital or would require frequent hospitalization without home and community-based services.

F. The anticipated average monthly cost to the medical assistance program to implement the individual's care

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plan, determined on a twelve-month basis, must not exceed the cost to medical assistance of providing inpatient hospital services and physician services for the individual.

G. An individual who is eligible for inpatient hospital service financial coverage by a third party payer and medical assistance is eligible for CAC services if the anticipated medical assistance payment for the CAC services is within the limit specified in item F. For purposes of this item, "third party payer" refers to Medicare and a person, entity, agency, or government program as defined in part 9505.0015, subpart 46.

H. The cost to medical assistance of CAC services specified in the individual's care plan falls within the limit specified in the waiver for the aggregate annual cost of CAC services provided under the waiver for the waiver year in which the individual is a recipient.

I. The total number of recipients to be served, including the applicant if approved, falls within the limit specified in the waiver.

9505.3530 REQUEST FOR CAC SERVICES.

Subpart 1. **Who may request service.** An individual or the representative of an individual who believes that the individual meets the criteria of part 9505.3520, items A to I may request participation in CAC according to parts 9505.3500 to 9505.3700. The request must be made to the department.

Subp. 2. **Response of department to request for CAC.** When the department receives a request for a determination of eligibility for CAC, the department shall determine which county will be the individual's county of financial responsibility and the estimated date or dates for the start of the individual's home and community-based services. The department shall designate an acting case manager and send the acting case manager the forms necessary to obtain the information required under part 9505.3540. The forms must be sent no later than five working days after receiving the request. If the acting case

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manager is not employed by the local agency of the applicant's county of service, the department shall notify the local agency about the request to participate in CAC and the designation of an acting case manager.

Subp. 3. **Local agency designation of team members.** No later than five working days after receiving the department's notice, the local agency of the applicant's county of service must designate a social worker and public health nurse to serve on the interdisciplinary team required under part 9505.3535.

9505.3535 INTERDISCIPLINARY TEAMS; ESTABLISHMENT AND MEMBERSHIP.

Subpart 1. **Applicant's interdisciplinary team.** No later than ten working days after being designated as an applicant's acting case manager, the acting case manager must form an interdisciplinary team. The acting case manager shall consult the applicant or, when it is appropriate, the applicant's representative in forming the team. The team must consist of at least the persons specified in items A to K.

A. the applicant or, when it is appropriate, the applicant's representative;

B. the acting case manager;

C. the applicant's physician;

D. the applicant's primary nurse;

E. in the case of an applicant who is an inpatient, a medical social worker designated by the hospital to assist in discharge planning for the applicant;

F. the county social worker designated under part 9505.3530, subpart 3;

G. the county public health nurse designated under part 9505.3530, subpart 3;

H. a representative of Services for Children with Handicaps if the applicant is under 21 years of age;

I. when it is appropriate, other persons who are expected to be the applicant's informal caregivers;

J. a representative of the local school district if the applicant is under 22 years of age; and

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K. other health care professionals providing services required by the applicant's medical condition, consistent with part 9505.0190 and Code of Federal Regulations, title 42, section 431.51.

Subp. 2. **Interdisciplinary team; reconvened.** The case manager must reconvene the interdisciplinary team established under subpart 1 when a reassessment is required to determine a recipient's continued eligibility for CAC. If possible, the case manager shall assure continuity of service of team members. At a minimum, the reconvened team must include the persons specified in items A to I.

A. the recipient or, when it is appropriate, the recipient's representative;

B. the case manager;

C. the recipient's primary caregiver;

D. the recipient's physician;

E. the county social worker designated under part 9505.3530, subpart 3;

F. the county public health nurse designated under part 9505.3530, subpart 3;

G. a representative of Services for Children with Handicaps if the recipient is under 21 years of age;

H. a representative of the local school district if the recipient is under 22 years of age; and

I. other health care professionals providing services required by the recipient's medical condition, consistent with part 9505.0190 and Code of Federal Regulations, title 42, section 431.51.

9505.3540 INTERDISCIPLINARY TEAM RESPONSIBILITIES; ASSESSMENT.

Subpart 1. **Assessment of applicant's service needs.** The team must assess the home and community-based services that an applicant will need to live in the community. The assessment must be completed on forms provided by the commissioner.

Subp. 2. **Assessment of financial resources.** The team must assess an applicant's financial resources to identify third

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party payers and other financial resources as defined in part 9505.0015, subpart 46, using forms provided by the commissioner.

Subp. 3. **Assessment of the applicant's home.** The team must assess the home in which the applicant lives or will live to determine if the applicant's health and safety can be assured in the residence. This assessment must be completed on forms provided by the commissioner. The assessment shall include a determination of the need for environmental modifications in the home as specified in part 9505.3610.

Subp. 4. **Assessment of person to be primary caregiver.** The team must assess the willingness and ability of the person who is expected to be the CAC applicant's primary caregiver. The team must report its assessment under this subpart on the form provided by the commissioner.

Subp. 5. **Authorization to release information.** The team must ask the applicant or the applicant's representative to sign forms that authorize the release of the applicant's medical records to the team for the assessment. A separate form supplied by the commissioner must be completed and signed for each authorization of release of information. The period of the authorization must not exceed one year. The following information must be on the form before the applicant's signature or, when it is appropriate, the signature of the applicant's representative:

A. the applicant's name;

B. the date of the authorization;

C. the information authorized;

D. the person authorized to give the information;

E. the person to whom the information is to be given;

F. a description of how the information will be used during the assessment to determine the appropriateness of CAC services; and

G. the date the authorization expires.

Subp. 6. **Rights, appeals, and freedom to choose.** The team must give the applicant or the applicant's representative written information about the applicant's rights under CAC

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including:

A. the right to appeal the assessment;

B. the right to choose among qualified providers of home and community-based services, consistent with part 9505.0190 and Code of Federal Regulations, title 42, section 431.51;

C. the right to confidentiality; and

D. the right to accept or reject a recommendation of the team to use home and community-based services rather than reside in a hospital.

The acting case manager must document compliance with this subpart by signing and submitting to the department forms supplied by the commissioner that state the required information was given to the applicant or, when it is appropriate, the applicant's representative.

Subp. 7. **Development of a care plan.** The interdisciplinary team shall develop a care plan for the applicant that is based on the information obtained in subparts 1 to 5. The plan must meet the requirements of subpart 8. The acting case manager must notify the department and estimate the additional time needed if the time required to complete the care plan and assessments required under this subpart exceeds the time specified in part 9505.0090, subpart 2. The applicant's care plan must be signed by the applicant or, when it is appropriate, the applicant's representative, the applicant's physician, and the acting case manager.

Subp. 8. **Contents.** The care plan developed by the interdisciplinary team for an applicant or recipient must contain at least the information specified in items A to D. The plan must be on forms provided by the commissioner. The care plan must include all health services approved by the individual's physician regardless of the funding source or sources available to pay the cost of the health services.

A. The recommendation of the team that the applicant be approved for services funded by CAC because the applicant meets the eligibility criteria under part 9505.3520 or, in the

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case of a recipient, continues to be approved for services funded by CAC because the applicant continues to meet the eligibility criteria under part 9505.3520.

B. A description of the health services necessary to maintain the individual in the community, including:

(1) home and community-based services needed by the individual;

(2) qualified providers of the home and community-based services selected by the applicant or, when it is appropriate, the applicant's representative or, in the case of a recipient, by the recipient or, when it is appropriate, the recipient's representative to meet the needs identified in subitem (1);

(3) the informal caregivers who are willing and able to provide services identified in subitem (1);

(4) the required frequency of the services;

(5) the anticipated date or dates on which the applicant's services must be started;

(6) the provisions for back-up services if there is an emergency;

(7) the cost of each service;

(8) the funding source for each service; and

(9) an estimate of the total cost of all health services in the care plan including home and community-based services.

C. Documentation that the team allowed the applicant or recipient or, when it is appropriate, the representative of the applicant or recipient to choose among the available qualified providers.

D. Documentation that the applicant or recipient or, when it is appropriate, the representative of the applicant or recipient, the acting case manager or case manager, and the physician of the applicant or recipient approve the home care plan.

Subp. 9. **Team recommendation.** After completing the assessments required in subparts 1 to 4 and the care plan

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required in subpart 8, the interdisciplinary team must recommend one of the following:

A. that the applicant remain a hospital inpatient;

B. that the applicant be admitted to a facility from the applicant's home. For purposes of this item, "facility" means a hospital as defined in part 9505.0175, subpart 16 or a long-term care facility as defined in part 9505.0175, subpart 23; or

C. that the applicant receive health services including home and community-based services in the community.

The team's recommendation must be supported by the assessments conducted under subparts 1 to 4 and the services specified in the applicant's care plan. The applicant's physician, the acting case manager or case manager and the applicant or, when it is appropriate, the applicant's representative must sign the application.

Subp. 10. **Transmittal of plan, assessments, and recommendations to the commissioner.** The team must submit the following documents to the commissioner for a determination of the applicant's eligibility for CAC services:

A. the completed assessments required under subparts 1 to 4;

B. the documentation required under subpart 6;

C. the request for CAC services, signed by the applicant or the applicant's representative;

D. the recommendation required under subpart 9; and

E. the care plan signed by the physician, case manager, and the applicant or the applicant's representative.

9505.3545 REASSESSMENT BY INTERDISCIPLINARY TEAM.

Subpart 1. **Reassessment required.** A recipient's need and eligibility for home and community-based services must be reassessed at least once every six months. The reassessment must be carried out by an interdisciplinary team convened by the recipient's case manager as specified in part 9505.3535, subpart 2. At a minimum, the reassessment shall include the items

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specified in part 9505.3540, subparts 1 and 3 to 9. The team must review and modify the recipient's care plan as necessary and appropriate to meet the recipient's needs.

Subp. 2. **Responsibility to assure reassessment.** A local agency is responsible to assure that a recipient's reassessment is completed as required under subpart 1. If the reassessment is not completed, the local agency shall be responsible for paying the costs of the services specified in the recipient's care plan and received by the recipient until the reassessment is completed and submitted to the department.

9505.3550 RECIPIENT'S TERMINATION FROM CAC.

A recipient shall be terminated from eligibility for CAC services when:

A. the recipient chooses not to use CAC services;

B. the recipient no longer needs CAC services as determined by a reassessment;

C. the recipient's condition requires continued hospitalization for an indefinite period as certified by the recipient's physician;

D. the recipient who has been hospitalized more than 30 consecutive days in a waiver year requires home and community-based services that are not available in the community;

E. the recipient is no longer eligible for medical assistance;

F. the recipient has third party payer coverage that pays the cost of inpatient hospital services to the extent CAC services are no longer cost-effective; or

G. the recipient's condition requires health services having a cost to medical assistance that is greater than the medical assistance cost of inpatient hospital services to the recipient.

9505.3560 CASE MANAGEMENT SERVICES.

Subpart 1. **Required service.** Case management services must be provided to a recipient. The lead agency shall be

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responsible for implementing the case management services required under parts 9505.3500 to 9505.3700.

Subp. 2. **Designation of case manager.** No later than five working days after receiving the department's notice that an applicant's request for CAC services has been approved, the lead agency must consult with the applicant or the applicant's representative and designate a case manager. The case manager must not have a financial interest in the services provided to the applicant other than the case manager's employment by the lead agency.

Subp. 3. **Case manager responsibilities.** The case manager or, when it is appropriate, the acting case manager must:

A. convene and coordinate the interdisciplinary team;

B. gather information needed to determine an individual's eligibility for CAC under parts 9505.3500 to 9505.3700;

C. inform applicants, recipients, and their representatives about the rights specified in part 9505.3540, subpart 6 and CAC services;

D. complete and submit forms required by the commissioner under parts 9505.3500 to 9505.3700;

E. locate resources that are available to provide the services specified in the recipient's care plan;

F. coordinate and arrange services specified in the recipient's care plan;

G. seek out other home and community-based services that may contribute to the recipient's quality of life while the recipient is residing in the community but that are not reimbursable under medical assistance or CAC. Examples of other services include legal, recreational, educational, vocational, and social services;

H. meet with the recipient or the recipient's representative in the recipient's home as necessary to assure the recipient's safety and welfare and assure implementation of the recipient's services as specified in the recipient's care plan;

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I. revise the care plan if the recipient's needs change between scheduled reassessments and, when it is appropriate, obtain the approval of the recipient's physician;

J. monitor costs of services to assure that the cost of the services specified in the care plan does not exceed the approved estimated cost of the care plan;

K. investigate whether the costs of the services specified in the applicant's or recipient's care plan can be met by a third party payer other than medical assistance or CAC. The case manager must document the investigation on the applicant's or recipient's care plan;

L. reconvene the interdisciplinary team at least every six months as required under part 9505.3545 or more often if necessary because of changes in the recipient's health or social needs;

M. participate in the recipient's reassessment as required under part 9505.3545 and submit the reassessment form to the department no later than ten working days after the reassessment is completed;

N. submit the care plan and revisions of the care plan to the commissioner for approval;

O. send to the department the information needed to carry out responsibilities under 9505.3680, subparts 1 and 2;

P. give notice of acceptance or rejection of an application or reduction, denial, or termination of benefits; and

Q. request the applicant, recipient, or the representative of the applicant or recipient, and the individual's physician to approve and sign the individual's care plan.

An applicant or recipient is ineligible for CAC services if the applicant or recipient or, when it is appropriate, the applicant's or recipient's representative fails to sign the care plan. The acting case manager of an applicant or the case manager of a recipient must explain to the person whose signature is being requested the consequences of failing to sign.

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Subp. 4. **Case manager reports about suspected abuse of a vulnerable adult.** A case manager who has reason to believe a recipient is or has been subject to abuse or neglect as defined in Minnesota Statutes, section 626.557, subdivision 2, that occurs at the recipient's residence or a place where the recipient receives CAC services shall immediately comply with the reporting and other actions required under Minnesota Statutes, section 626.557. The case manager shall cooperate with the responsible county authority to assure the recipient's health and safety during the investigation. The case manager must request a report from the responsible county authority in order to take the action required in subpart 6.

Subp. 5. **Case manager reports about suspected abuse of a child.** A case manager who has reason to believe a recipient who is a child is or has been subject to abuse or neglect as defined in Minnesota Statutes, section 626.556 shall immediately report the circumstances of alleged abuse or neglect to the county authority responsible for assuring the protection of children. The case manager shall cooperate with the responsible county authority to assure the recipient's health and safety during the investigation. The case manager must request a report from the responsible county authority in order to take the action required in subpart 6.

Subp. 6. **Other actions required of case manager.** When the case manager receives the findings of the investigation carried out under subpart 4 or 5, the case manager shall determine whether a reassessment of the recipient according to part 9505.3545 is needed to amend the recipient's care plan. The case manager shall take other actions as needed to assure the recipient's health and safety, such as (1) arranging for the services of another CAC provider, (2) working out another living arrangement for the recipient or, (3) withdrawing the CAC service or services. The case manager shall forward the amended care plan to the commissioner for approval.

9505.3570 HOME HEALTH SERVICES.

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Home health services established under parts 9505.0170 to 9505.0475 are available to a recipient except that the limits placed on the amount, duration, and scope of the services eligible for medical assistance payment shall be as specified in the recipient's plan of care.

9505.3575 HOMEMAKER SERVICES.

Subpart 1. **Eligibility for service.** Homemaker services are available under CAC if necessary to enable a recipient to remain in the community.

Subp. 2. **Homemaker services provider; lead agency or contractor.** The lead agency may provide directly or may contract for homemaker services that are specified in the recipient's care plan. If the lead agency directly provides homemaker services, 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.

Subp. 3. **Homemaker service standards.** The lead agency shall assure that homemaker services to a recipient are provided by the homemaker according to parts 9565.1000 to 9565.1300 and the recipient's care plan.

9505.3580 RESPITE CARE SERVICES.

Subpart 1. **Eligibility for service.** Respite care services are available under CAC if the service is necessary to maintain the recipient during a time when the primary caregiver is unable to care for the recipient. Respite care services to a recipient are limited to 720 hours per waiver year.

Subp. 2. **Provider standards.** Respite care may be provided in an out-of-home setting as specified in item A or in the recipient's home as specified in item B.

A. Out-of-home respite care must be provided in a facility approved by the lead agency such as a hospital, nursing home, foster home, or community residential facility. When out-of-home respite care is provided, the facility must be one

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that meets state licensure standards.

B. A registered nurse or a public health nurse may give respite care in the recipient's home. The person providing respite care services must act in the place of the primary caregiver and shall be available to the recipient throughout the absence of the primary caregiver.

Subp. 3. **Contract required.** The lead agency shall contract with each person, facility, agency, or entity that provides respite care services. If the respite care is provided in the recipient's home, the contract must require the service to be provided as specified in subpart 2, item B. The lead agency shall monitor the contractor's compliance with the terms of the contract.

9505.3585 PHYSICIAN SERVICES.

Physician services as specified in part 9505.0345 to a CAC recipient may include home visits as necessary to maintain the recipient's safe care in the community.

9505.3600 COUNSELING AND TRAINING SERVICES.

Subpart 1. **Eligibility to receive counseling and training services.** Counseling and training services are available under CAC and shall be provided to a recipient, primary caregiver, and to members of the recipient's family with whom the recipient lives or who routinely care for the recipient. For purposes of this part, "member of the recipient's family" or "family member" refers to the recipient's parent, spouse, children, friends, relatives, foster family, or relatives-in-law. The term does not include individuals who are employed to care for the recipient.

Subp. 2. **Purpose of training.** The training must be for the purpose of increasing the ability of a primary caregiver or a member of the recipient's family to maintain and care for the recipient at home. It shall include the use of equipment and treatment regimens as specified in the recipient's care plan and training updates as may be necessary to safely maintain the recipient at home.

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Subp. 3. **Purpose of counseling.** Counseling under CAC must be designed to help the recipient, the primary caregiver, and the recipient's family members handle crises related to the recipient's condition, develop coping strategies related to the recipient's daily care, and reduce stress.

Subp. 4. **Case manager approval required.** Counseling and training services under CAC must be approved by the case manager and must be specified in the recipient's care plan.

Subp. 5. **Eligibility to provide counseling and training.** A person providing counseling and training services to a recipient, a primary caregiver, or a recipient's family member must be the recipient's physician, a registered nurse, a public health nurse, a county social worker, or a medical social worker, or other qualified person as specified in the recipient's care plan and approved by the case manager. The person providing training service must determine and must document in the recipient's care plan whether a person being trained as the primary caregiver is competent to provide the services required to maintain the recipient at home.

9505.3610 ENVIRONMENTAL MODIFICATIONS IN THE HOME.

Subpart 1. **Eligibility for service.** An environmental modification in the home of a recipient is available under CAC if the modification is:

A. necessary to avoid the recipient's hospitalization;

B. approved and authorized by the recipient's case manager;

C. specified in the recipient's care plan; and

D. not available from another funding source. Examples of other funding sources are Services for Children with Handicaps and the Minnesota Housing Finance Agency.

Subp. 2. **Provider standards.** An environmental modification to the home must be completed according to all applicable state and city building codes by a provider who has been approved by the case manager. The lead agency shall

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specify the terms of the service to be provided in a contract or service agreement between the agency and the provider approved by the case manager. The lead agency must assure that the environmental modification in the home, when completed, meets the terms specified in the contract or service agreement between the lead agency and the provider.

9505.3620 MEDICAL EQUIPMENT.

Subpart 1. **Eligibility for medical equipment and supplies.** Medical equipment and supplies that are generally available to an individual in an institution are available under CAC for home use if:

A. the medical equipment and supplies are specified in the recipient's plan of care;

B. CAC is the only funding source available to the recipient in regard to the medical equipment and supplies; and

C. the medical equipment and supplies meet the requirements of part 9505.0310 in regard to rental, purchase, and safeguarding of recipient care.

Subp. 2. **Prior approval required.** Medical equipment and supplies require prior approval of the commissioner if:

A. they are not in the recipient's care plan approved by the commissioner under part 9505.3550;

B. they are medically necessary;

C. they exceed $25 in value per month; and

D. CAC is the only funding source for the medical equipment and supplies.

The case manager must submit to the commissioner an addendum to the recipient's care plan that documents compliance with this subpart. The commissioner shall determine whether the medical equipment and supplies meet the requirements of parts 9505.3500 to 9505.3700.

Subp. 3. **Exemption from limitation on type of equipment and supplies available.** The limitations on the types of equipment or supplies set in part 9505.0310, subpart 1, item A, and subpart 4, item A do not apply to durable medical equipment

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and supplies available under CAC.

9505.3622 MEDICAL TRANSPORTATION.

Transportation of a recipient for medical purposes is available under CAC if the transportation is specified in the recipient's care plan to provide access to a medically necessary service and if the transportation lies outside the scope of the local agency's procedure to assure access as required under part 9505.0140, subpart 2.

9505.3624 PRESCRIBED DRUGS.

Subpart 1. **Eligibility for service.** Prescribed drugs are available under CAC if the drug is prescribed by the recipient's physician, is specified in the recipient's care plan, and would be available under medical assistance to the recipient as an inpatient, as provided by Minnesota Statutes, section 256B.0625, subdivision 13.

Subp. 2. **Number of prescribed drugs available to recipient.** The availability of prescribed drugs under CAC is subject to the limitations under part 9505.0340. However, the number of different prescribed drugs that a recipient may fill or refill per month is not limited.

9505.3626 OTHER PROFESSIONAL SERVICES; THERAPY.

Subpart 1. **Eligibility for other professional services; therapies available as medical assistance services.** A recipient is eligible for a therapy that is available to medical assistance recipients under part 9500.1070. The therapy must be provided by a physical therapist, occupational therapist, speech-language pathologist, or respiratory therapist. The therapy provided to the recipient must comply with the provider standards set in parts 9500.1070 and 9505.3500 to 9505.3700.

Subp. 2. **Eligibility for other professional services; nutritional therapy.** Nutritional therapy is available under CAC. The therapy must be provided by a nutritionist.

Subp. 3. **Service limitations.** The amount, duration, and scope of therapy provided to a recipient by a physical

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therapist, occupational therapist, speech-language pathologist, respiratory therapist, or nutritionist must be ordered by the recipient's physician and specified in the recipient's care plan.

9505.3630 FOSTER CARE.

Subpart 1. **Eligibility for payment.** Foster care services to a recipient are available under CAC if the services provide ongoing residential and support services which exceed the scope of the services provided through Title IV-E or the Minnesota Supplemental Aid Program. Payment does not include room and board. For purposes of this part, "Title IV-E" means the federal program established by the Social Security Act that reimburses administrative and training costs incurred in providing services under United States Code, title 42, sections 470 to 479 and 670 to 679. "Minnesota Supplemental Aid Program" means the program established in Minnesota Statutes, section 256D.37.

Subp. 2. **Provider standards.** A provider of foster care services must comply with a standard specified in item A or B.

A. A provider of foster care services to a recipient under 18 years of age must be licensed according to parts 9545.0010 to 9545.0260.

B. A provider of foster care services to a recipient who is at least 18 years of age must be licensed according to parts 9555.5105 to 9555.6265.

9505.3635 EXCLUDED SERVICES.

The following services in items A to F are not available under CAC:

A. room and board except for respite care provided outside of the recipient's residence;

B. respite care for a recipient of foster care provided under CAC if the payment agreement with the foster care provider includes the payment amount for the respite care to be purchased by the foster care provider;

C. health services for which other funding sources are available;

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D. a CAC service to an individual who is not a recipient;

E. a CAC service that is not specified in the recipient's care plan as approved by the commissioner or, in the case of medical transportation under part 9505.3622, the approval of the recipient's case manager; and

F. a CAC service for a purpose other than respite care while a recipient is an inpatient as defined in part 9505.0175, subpart 17.

9505.3640 LOCAL AGENCY RESPONSIBILITIES.

Subpart 1. **Determination of applicant's eligibility for medical assistance.** A local agency must determine a CAC applicant's eligibility for medical assistance and must redetermine a recipient's eligibility for medical assistance. The determination and redetermination shall be as specified in parts 9505.0010 to 9505.0150, except that the provisions of part 9505.0075 relating to the availability of parental or spousal income and assets shall not apply. Although the local agency making the determination must be the local agency of the applicant's or recipient's county of financial responsibility, the local agency obtaining the information required under parts 9505.0010 to 9505.0150 may be the local agency in the county of service.

Subp. 2. **Designation of lead agency.** A local agency that is the county of service for a CAC applicant or recipient must designate a lead agency to administer the county's community alternative care program. The designated lead agency may be in the recipient's county of residence or service if different from the county of financial responsibility.

Subp. 3. **Calculation of parental or spousal contribution.** The local agency must determine the financial contribution to be made by a recipient's parent or spouse, as appropriate, for services to the recipient. The financial contribution of a parent or spouse shall be determined according to Minnesota Statutes, sections 256B.14 and 252.27, and appropriate rules

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adopted under those statutes. The refusal or failure of a recipient's obligated parent or spouse to pay the contribution does not affect the recipient's eligibility for medical assistance and CAC.

The local agency of the recipient's county of financial responsibility shall refer the refusal or failure to pay to the county attorney for action to enforce payment of the contribution.

9505.3645 LEAD AGENCY RESPONSIBILITIES.

Subpart 1. **Enrollment as CAC provider.** A lead agency must enroll under part 9505.0195 as a provider of CAC services.

Subp. 2. **Compliance with rules and local agency requirements.** A lead agency must comply with the requirements of parts 9505.3500 to 9505.3700 and the local agency that made the designation under part 9505.3640, subdivision 2.

Subp. 3. **Administrative functions.** A lead agency is responsible to perform the following functions in regard to CAC services to a recipient:

A. establish agreements and contracts to provide the recipient's CAC services as in part 9505.3650, subpart 2;

B. review CAC provider billings for approval for payment according to the provider's contract, purchase agreement, or service agreement with the lead agency;

C. furnish billings for CAC services according to the procedures of part 9505.0450;

D. ensure that the projected cost to medical assistance for the services specified in the recipient's care plan does not exceed the cost to medical assistance if the recipient resided in a hospital;

E. make available to the commissioner records of funds expended for CAC services; and

F. maintain and make available to the commissioner records of health services provided to recipients.

Subp. 4. **Services to recipient.** A lead agency must assure that necessary safeguards are taken to protect the health and

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welfare of a recipient. For this purpose, the lead agency must:

A. require CAC services to be provided as specified in parts 9505.3500 to 9505.3700, either directly or through a contract or purchase of service agreement as specified in part 9505.3650;

B. assure a CAC service, other than respite care, is not provided to a recipient while the recipient is an inpatient as defined in part 9505.0175, subpart 17; and

C. monitor providers of CAC services using the criteria in part 9505.3650.

9505.3650 PROVIDERS OF CAC SERVICES.

Subpart 1. **Criteria for selecting a CAC provider.** A provider of home and community-based services under CAC must meet the criteria in items A to C.

A. The provider must be employed by the county or have agreed as specified in subpart 2 to provide home and community-based services under CAC.

B. The provider must meet all licensure requirements and professional standards applicable to the service or services being provided as specified in parts 9505.3500 to 9505.3700.

C. The provider must not be a primary caregiver or responsible relative of the recipient to whom the provider is furnishing the home and community-based service.

Subp. 2. **Agreement to provide CAC services.** A lead agency may provide a CAC service directly or indirectly. If the lead agency chooses to provide the CAC service indirectly, the agency must have a contract, purchase agreement, or service agreement with the CAC service provider that specified the information in items A to I:

A. the beginning and ending dates of the contract or agreement;

B. the duties and responsibilities of the provider including compliance with applicable certifications, licensures, standards, and supervision of employees as required under parts 9505.3500 to 9505.3700;

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C. the person or persons to be served as specified in the recipient's care plan;

D. an agreement to provide the service according to the amount, frequency, and scope specified in the care plan of the person being served;

E. the payment amount to be received for the service and the provider's agreement to accept this amount as payment in full;

F. the reports and records to be kept by the provider and given to the lead agency;

G. the provider's agreement to comply with the Minnesota Government Data Practices Act;

H. the provider's documentation of an individual abuse prevention plan that complies with parts 9555.8000 to 9555.8500; and

I. the conditions under which the lead agency shall terminate the provider's contract or agreement.

9505.3660 CAC PROVIDER RECORDS.

The lead agency and a CAC provider under contract with the lead agency must maintain for at least five years complete program and fiscal records and supporting documentation identifying the 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 provider's records are subject to the maintenance schedule, audit availability requirements, and other provisions in parts 9505.1750 to 9505.2150.

9505.3670 RATES FOR CAC SERVICES.

Subpart 1. **Maximum CAC service rate.** Unless otherwise specified by the legislature, the commissioner shall annually set the maximum rate that is available to a county as reimbursement to a provider for a CAC service. The rates for CAC services must be consistent with medical assistance rates for comparable services. Annually on July 1 after the effective date of parts 9505.3500 to 9505.3700, the commissioner shall

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authorize an increase in the CAC service rates available to a county as reimbursement to a CAC provider up to the percentage change forecast by the Home Health Agency Market Basket. The Home Health Agency Market Basket is published by Data Resources and is subject to quarterly revision. The Home Health Agency Market Basket is incorporated by reference and is available through the Minitex interlibrary loan system.

Subp. 2. **Notice to counties.** By June 1 of each year, the commissioner shall notify a lead agency of the statewide maximum rate allowed for payment of providing CAC services under subpart 1. Additionally, the commissioner shall notify the counties in writing of the percentage increase allowed under subpart 1.

Subp. 3. **County CAC service rate.** A county may set rates for CAC services not to exceed the rates established in subpart 1. Under no circumstances is the department responsible for payment of rates higher than those established under subpart 1 and any amounts paid in excess of those rates shall be recoverable by the commissioner. County rates are subject to audit by the commissioner.

9505.3680 DEPARTMENT RESPONSIBILITIES.

Subpart 1. **Review and approval of CAC applications.** The commissioner must review and approve or deny each request for eligibility for the community alternative care program according to the criteria of part 9505.3520. The commissioner must determine whether the applicant is eligible for home and community-based services under CAC. No later than 15 working days after receiving the information required under part 9505.3540 to determine the applicant's eligibility for CAC, the commissioner must notify the acting case manager and the lead agency of its determination or of the additional information needed to make the determination.

Subp. 2. **Review of care plan and eligibility reassessments.** The commissioner must approve or deny care plan and eligibility reassessment recommendations according to the criteria of part 9505.3520. The recipient's preexisting care

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plan shall remain in effect pending the commissioner's approval or denial of the reassessment recommendation.

Subp. 3. **Records.** The department must maintain records related to the community alternative care program for a period of at least five years.

Subp. 4. **Monitor program expenses.** The department must monitor CAC expenditures to assure that the expenditures do not exceed the approved waiver limits for the home and community-based services under CAC.

9505.3690 BILLING FOR CAC SERVICES.

A CAC provider must submit a claim for payment for a CAC service specified in a recipient's care plan in the manner specified by the commissioner. A claim under this part must not exceed the amount specified in the contract, purchase agreement, or service agreement between the CAC provider and the lead agency. The CAC 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.

9505.3700 APPEALS.

Subpart 1. **Appealable actions.** An applicant assessed under part 9505.3540 or a recipient reassessed under part 9505.3545 may appeal if one of the following actions is taken by the department or the local or lead agency:

A. a CAC service is denied;

B. eligibility for CAC services is not determined with reasonable promptness; or

C. a recipient's CAC services are reduced, suspended, or terminated.

Subp. 2. **Actions that are not appealable.** A denial, reduction, suspension, or termination of CAC services is not an appealable action if one of the following conditions applies:

A. the cost of the applicant's or recipient's home and community-based care exceeds the cost of hospital care;

B. the waiver aggregate average cost would be exceeded;

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C. there are no openings available in the program; or

D. the case manager withdraws the CAC service or services as provided under part 9505.3560, subpart 6.

Subp. 3. **Notice of right to appeal.** An applicant assessed under part 9505.3540 or a recipient reassessed under part 9505.3545 has the right to appeal an action described in subpart 1. At the time a requested service is denied, reduced, suspended, or terminated by the case manager, lead agency, or department, the case manager must review with and provide the individual written notice about the proposed action and about the right to appeal. The notice must state the reasons for an appealable action, and an explanation of the right to appeal and how to appeal. The notice must also state that the recipient's ongoing CAC services will not be reduced, suspended, or terminated if the appeal is filed before the date specified in the notice, unless the recipient requests in writing not to receive CAC services while the appeal is pending.

Subp. 4. **Submission of appeals.** An applicant assessed under part 9505.3540 or a recipient reassessed under part 9505.3545 who wants to appeal must submit the appeal in writing to the local agency of the county of service or to the department. The appeal must be received by the department no later than 30 days after the recipient is made aware of the action taken in subpart 1 or no later than 90 days after the recipient is made aware of the action taken in subpart 1 if good cause reason for delay can be shown.

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

Subp. 6. **Continuation of services pending an appeal.** If a recipient appeals a denial, reduction, suspension, or termination of CAC services that the recipient has been receiving on an ongoing basis and that are part of the recipient's care plan approved by the recipient's physician, the lead agency must continue to provide the ongoing CAC services at the level specified in the recipient's care plan until a

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decision on the appeal is recommended by the department's referee and adopted by the commissioner. Nothing in parts 9505.3500 to 9505.3700 shall prohibit the department from seeking reimbursement from the recipient for the costs of providing CAC services pending a decision on an appeal if the order adopted by the commissioner is adverse to the recipient.

Approved
by Revisor _____

Office of the Revisor of Statutes

Administrative Rules

TITLE: Proposed Permanent Rules Relating to Community Alternative Care Program

AGENCY: Department of Human Services

MINNESOTA RULES: Chapter 9505

INCORPORATION BY REFERENCE:

Part 9505.3670, subpart 1: Home Health Agency Market Basket published by Data Resources. Available through Minitex interlibrary loan system.

The attached rules are approved for publication in the State Register

Kathleen T. Harrington
Assistant Revisor

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ADMINISTRATIVE HEARINGS

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Amendment of Rules of the State Department of Human Services Governing Community Alternative Care for Chronically Ill Individuals, Minnesota Rules, parts 9505.3500 to 9505.3700.

NOTICE OF INTENT TO ADOPT A RULE WITHOUT A PUBLIC HEARING AND NOTICE OF INTENT TO ADOPT A RULE WITH A PUBLIC HEARING IF TWENTY-FIVE OR MORE PERSONS REQUEST A HEARING

(1) Notice is hereby given that the State Department of Human Services proposes to adopt the above-entitled rule without a public hearing following the procedures set forth in Minnesota Statutes, section 14.22 to 14.28. The specific statutory authority to adopt the rule is Minnesota Statutes, section 256B.49.

(2) Persons interested in this rule shall have 30 days in which to submit comment in support of or in opposition to the proposed rule or any part or subpart of the rule and comment is encouraged. (3) Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. (4) If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. (6) Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. (7) If a public hearing is required, the agency will proceed pursuant to Minnesota Statutes, section 14.131 to 14.20. PLEASE NOTE THAT IF TWENTY-FIVE OR MORE PERSONS SUBMIT WRITTEN REQUESTS FOR A PUBLIC HEARING WITHIN THE 30-DAY COMMENT PERIOD, A HEARING WILL BE HELD ON Monday, October 1, 1990, UNLESS A SUFFICIENT NUMBER WITHDRAW THEIR REQUEST, IN ACCORDANCE WITH THE NOTICE OF PUBLIC HEARING ON THESE SAME RULES PUBLISHED IN THIS STATE REGISTER AND MAILED TO PERSONS REGISTERED WITH THE DEPARTMENT OF HUMAN SERVICES. To verify whether a hearing will be held, please call the Department of Human Services between September 20, 1990 and September 28, 1990 at (612) 297 4301.

(5) Persons who wish to submit comments or a written request for a public hearing must submit such comments or requests to:

Eleanor Weber
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816

Comments or requests for a public hearing must be received by the Department by 4:30 p.m. on Wednesday, September 19, 1990.

(8) The proposed rule may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed rule as noticed.

(11) A free copy of this rule is available upon request for your review from:

Nancy Bishop
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816
(612) 296 7454.

A copy of the proposed rule may be viewed at any of the county welfare or human service agencies in the State of Minnesota.

(11) Parts 9505.3500 to 9505.3700 establish the standards and procedures applicable to community alternative care (CAC) services available under a waiver from the Health Care Financing Administration to chronically ill individuals who are hospitalized or who require frequent hospitalization, who are eligible to receive medical assistance, and who meet the eligibility requirements specified in the rules. The proposed rules will specify: 1. the home and community-based services available under CAC; 2. conditions of eligibility for CAC; 3. the procedures for requesting CAC and determining eligibility for CAC; 4. the duties of the case manager and interdisciplinary team in assessing the CAC applicant's or recipient's health and needed health services and in recommending the health services needed; 5. the development and contents of a care plan for the CAC applicant or recipient; 6. conditions for termination from eligibility for CAC services; 7. standards for the following CAC services authorized under the waiver from the Health Care Financing Administration: home health, homemaker, respite care, counseling and training, environmental modifications in the home, medical equipment, medical transportation, therapy, foster care; 8. local agency responsibilities, including the designation of a lead agency to administer the county's CAC program; 9. the method of calculating a parental or spousal financial contribution toward the cost of CAC services; 10. criteria for and method of selecting a CAC service provider and the duties of the providers; 11. the maximum CAC services rates and their annual adjustment to be made by the commissioner; 12. the commissioner's responsibility to determine an applicant's eligibility for CAC; 13. the annual dollar limits that may be expended from medical assistance and CAC funds for health services to a recipient and to all Minnesota CAC recipients; and 14. actions related to CAC applications and services that are appealable and the appeal process.

(12) A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the

proposed rule has been prepared and is available upon request from:

Nancy Bishop
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816
(612) 296 7454.

(13) Adoption of these rules will not result in additional spending by local public bodies in the excess of $100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section 14.11.

(9) If no hearing is required upon adoption of the rule, the rule and the required supporting documents will be delivered to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to:

Eleanor Weber
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816.

State of Minnesota

Dated: 7-31-90

ANN WYNIA
Commissioner

STATE OF MINNESOTA

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ADMINISTRATIVE HEARINGS

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Amendment of Department of Human Services Rules Governing Community Alternative Care for Chronically Ill Individuals, Minnesota Rules, parts 9505.3500 to 9505.3700.

NOTICE OF HEARING AND NOTICE OF INTENT TO CANCEL HEARING IF FEWER THAN TWENTY-FIVE PERSONS REQUEST A HEARING IN RESPONSE TO NOTICE OF INTENT TO ADOPT RULES WITHOUT A PUBLIC HEARING

NOTICE IS HEREBY GIVEN that a public hearing on the above-entitled matter will be held in the Department of Human Services, in Room 1B, 444 Lafayette Road, St. Paul, MN 55155 on Monday, October 1, 1990 commencing at 9:00 a.m. and continuing until all interested or affected persons have an opportunity to participate. (8) The proposed rules may be modified as a result of the hearing process. Therefore, if you are affected in any manner by the proposed rules, you are urged to participate in the rule hearing process.

(4) PLEASE NOTE, HOWEVER, THAT THE HEARING WILL BE CANCELLED IF FEWER THAN TWENTY-FIVE PERSONS REQUEST A HEARING IN RESPONSE TO THE NOTICE OF INTENT TO ADOPT THESE SAME RULES WITHOUT A PUBLIC HEARING PUBLISHED IN THIS STATE REGISTER AND MAILED TO PERSONS REGISTERED WITH THE DEPARTMENT OF HUMAN SERVICES. To verify whether a hearing will be held, please call the Department of Human Services between September 20, 1990 and September 28, 1990 at (612) 297 4301.

Following the agency's presentation at the hearing, all interested or affected persons will have an opportunity to participate. Such persons may present their views either orally at the hearing or in writing at any time prior to the close of the hearing record. All evidence presented should be pertinent to the matter at hand. Written material not submitted at the time of the hearing which is to be included in the hearing record may be mailed to Aministrative Law Judge Peter C. Erickson, 500 Flour Exchange Building, 310 Fourth Avenue South, Minneapolis, Minnesota 55415; telephone (612) 341-7606, either before the hearing or within five working days after the public hearing ends. The Administrative Law Judge may at the hearing, order the record be kept open for a longer period not to exceed 20 calendar days. The comments received during the comment period shall be available for review at the Office of Administrative Hearings. Following the close of the comment period the agency and all interested persons have three business days to respond in writing to any new information submitted during the comment period. During the three-day period, the agency may indicate in writing whether there are amendments suggested by other persons which the agency is willing to adopt. No additional evidence may be submitted during the three-day period. The written responses shall be added to the rulemaking record. Upon the close of the record the Administrative Law Judge will write a report as provided for in

Minnesota Statutes, sections 14.15 and 14.50. The rule hearing is governed by Minnesota Statutes, sections 14.14 to 14.20 and by Minnesota Rules, parts 1400.0200 to 1400.1200. Questions about procedure may be directed to the Administrative Law Judge.

(11) Parts 9505.3500 to 9505.3700 establish the standards and procedures applicable to community alternative care (CAC) services available under a waiver from the Health Care Financing Administration to chronically ill individuals who are hospitalized or who require frequent hospitalization, who are eligible to receive medical assistance, and who meet the eligibility requirements specified in the rules. The proposed rules will specify: 1. the home and community-based services availble under CAC; 2. conditions of eligibility for CAC; 3. the procedures for requesting CAC and determining eligibility for CAC; 4. the duties of the case manager and interdisciplinary team in assessing the CAC applicant's or recipient's health and needed health services; 5. the development and contents of a care plan for the CAC applicant or recipient; 6. conditions for termination from eligibility for CAC services; 7. standards for the following CAC services authorized under the waiver from the Health Care Financing Administration: home health, homemaker, respite care, counseling and training, environmental modifications in the home, medical equipment, medical transportation, therapy, foster care; 8. local agency responsibilities, including the designation of a lead agency to administer the county's CAC program; 9. the method of calculating a parental or spousal financial contribution toward the cost of CAC services; 10. criteria for and method of selecting CAC service providers and the duties of the providers; 11. the maximum CAC service rates and their annual adjustment to be made by the commissioner; 12. the commissioner's responsibility to determine an applicant's eligibility for CAC; 13. the annual dollar limits that may be expended from medical assistance and CAC funds for health services to a recipient and to all Minnesota CAC recipients; and 14. actions related to CAC application and services that are appealable and the appeal process.

(7) The agency's authority to adopt the proposed rules is contained in Minnesota Statutes, section 256B.49.

(13) Adoption of these rules will not result in additional spending by local public bodies in excess of $100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section 14.11.

(14) Copies of the proposed rules are now available and at least one free copy may be obtained by writing to:

Nancy Bishop
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816.

This rule is also available for viewing at each of the county welfare or human service agencies in the State of Minnesota.

Additional copies will be available at the hearing. If you have any questions on the content of the rule contact Eleanor Weber at (612) 297 4301.

NOTICE: Any person may request notification of the date on which the Administrative Law Judge's report will be available, after which date the agency may not take any final action on the rules for a period of five working days. If you desire to be notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the Administrative Law Judge. Any person may request notification of the date on which the rules were adopted and filed with the secretary of state. The notice must be mailed on the same day the rules are filed. If you want to be so notified you may so indicate at the hearing or send a request in writing to the agency at any time prior to the filing of the rules with the secretary of state.

(12) NOTICE IS HEREBY GIVEN that a Statement of Need and Reasonableness is now available for review at the agency and at the Office of Administrative Hearings. The Statement of Need and Reasonableness includes a summary of all the evidence and argument which the agency anticipates presenting at the hearing justifying both the need for and reasonableness of the proposed rules. Copies of the Statement of Need and Reasonableness may be reviewed at the agency or the Office of Administrative Hearings and copies may be obtained from the Office of Administrative Hearings at the cost of reproduction.

Minnesota Statutes, chapter 10A, requires each lobbyist to register with the State Ethical Practices Board within five days after he or she commences lobbying. A lobbyist is defined in Minnesota Statutes, section 10A.01, subdivision 11, as any individual:

(a) engaged for pay or other consideration, or authorized by another individual or association to spend money, who spends more than five hours in any month or more than $250, not including travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communication or urging others to communicate with public officials; or

(b) who spends more than $250, not including traveling expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials.

The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 625 North Robert Street, St. Paul, Minnesota 55101, telephone (612) 296-5148.

Dated: 7-31-90

ANN WYNIA
Commissioner

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HEARINGS

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Amendment of the State Department of Human Services Rules Governing Community Alternative Care for Chronically Ill Individuals, Minnesota Rules, Parts 9505.3500 to 9505.3700

AFFIDAVIT OF MAILING

Joyce Pederson, being first duly sworn, deposes and says:

That on the 15th day of August, 1990, at the City of St. Paul, County of Ramsey, State of Minnesota, I mailed the attached Notices by depositing in the State of Minnesota Central Mail System for first class mailing, a copy thereof, properly enveloped, with postage prepaid, to all persons and associations who have requested that their names be placed on file with the Department of Human Services for the purpose of receiving notice of hearing by this Department.

Joyce Pederson

Subscribed and sworn to before me

this 15 day of August, 1990

Claudia A. Eliason

CLAUDIA A. ELIASON
NOTARY PUBLIC-MINNESOTA
WASHINGTON COUNTY
MY COMMISSION EXPIRES NOVEMBER 15, 1990

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Amendment of Rules of the State Department of Human Services Governing Community Alternative Care for Chronically Ill Individuals, Minnesota Rules, parts 9505.3500 to 9505.3700.	NOTICE OF INTENT TO ADOPT A RULE WITHOUT A PUBLIC HEARING AND NOTICE OF INTENT TO ADOPT A RULE WITH A PUBLIC HEARING IF TWENTY-FIVE OR MORE PERSONS REQUEST A HEARING

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Persons interested in this rule shall have 30 days in which to submit comment in support of or in opposition to the proposed rule or any part or subpart of the rule and comment is encouraged. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to Minnesota Statutes, section 14.131 to 14.20. PLEASE NOTE THAT IF TWENTY-FIVE OR MORE PERSONS SUBMIT WRITTEN REQUESTS FOR A PUBLIC HEARING WITHIN THE 30-DAY COMMENT PERIOD, A HEARING WILL BE HELD ON Monday, October 1, 1990, UNLESS A SUFFICIENT NUMBER WITHDRAW THEIR REQUEST, IN ACCORDANCE WITH THE NOTICE OF PUBLIC HEARING ON THESE SAME RULES PUBLISHED IN THIS STATE REGISTER AND MAILED TO PERSONS REGISTERED WITH THE DEPARTMENT OF HUMAN SERVICES. To verify whether a hearing will be held, please call the Department of Human Services between September 20, 1990 and September 28, 1990 at (612) 297 4301.

Persons who wish to submit comments or a written request for a public hearing must submit such comments or requests to:

Eleanor Weber
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816

Comments or requests for a public hearing must be received by the Department by 4:30 p.m. on Wednesday, September 19, 1990.

The proposed rule may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed rule as noticed.

A free copy of this rule is available upon request for your review from:

Nancy Bishop
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816
(612) 296 7454.

A copy of the proposed rule may be viewed at any of the county welfare or human service agencies in the State of Minnesota.

Parts 9505.3500 to 9505.3700 establish the standards and procedures applicable to community alternative care (CAC) services available under a waiver from the Health Care Financing Administration to chronically ill individuals who are hospitalized or who require frequent hospitalization, who are eligible to receive medical assistance, and who meet the eligibility requirements specified in the rules. The proposed rules will specify: 1. the home and community-based services available under CAC; 2. conditions of eligibility for CAC; 3. the procedures for requesting CAC and determining eligibility for CAC; 4. the duties of the case manager and interdisciplinary team in assessing the CAC applicant's or recipient's health and needed health services and in recommending the health services needed; 5. the development and contents of a care plan for the CAC applicant or recipient; 6. conditions for termination from eligibility for CAC services; 7. standards for the following CAC services authorized under the waiver from the Health Care Financing Administration: home health, homemaker, respite care, counseling and training, environmental modifications in the home, medical equipment, medical transportation, therapy, foster care; 8. local agency responsibilities, including the designation of a lead agency to administer the county's CAC program; 9. the method of calculating a parental or spousal financial contribution toward the cost of CAC services; 10. criteria for and method of selecting a CAC service provider and the duties of the providers; 11. the maximum CAC services rates and their annual adjustment to be made by the commissioner; 12. the commissioner's responsibility to determine an applicant's eligibility for CAC; 13. the annual dollar limits that may be expended from medical assistance and CAC funds for health services to a recipient and to all Minnesota CAC recipients; and 14. actions related to CAC applications and services that are appealable and the appeal process.

A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the

proposed rule has been prepared and is available upon request from:

Nancy Bishop
Rules and Bulletins Division
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444 Lafayette Road
St. Paul, MN 55155-3816
(612) 296 7454.

Adoption of these rules will not result in additional spending by local public bodies in the excess of $100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section 14.11.

If no hearing is required upon adoption of the rule, the rule and the required supporting documents will be delivered to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to:

Eleanor Weber
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816.

State of Minnesota

Dated: 7-31-90

ANN WYNIA
Commissioner

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Amendment of Department of Human Services Rules Governing Community Alternative Care for Chronically Ill Individuals, Minnesota Rules, parts 9505.3500 to 9505.3700.	NOTICE OF HEARING AND NOTICE OF INTENT TO CANCEL HEARING IF FEWER THAN TWENTY-FIVE PERSONS REQUEST A HEARING IN RESPONSE TO NOTICE OF INTENT TO ADOPT RULES WITHOUT A PUBLIC HEARING

NOTICE IS HEREBY GIVEN that a public hearing on the above-entitled matter will be held in the Department of Human Services, in Room 1B, 444 Lafayette Road, St. Paul, MN 55155 on Monday, October 1, 1990 commencing at 9:00 a.m. and continuing until all interested or affected persons have an opportunity to participate. The proposed rules may be modified as a result of the hearing process. Therefore, if you are affected in any manner by the proposed rules, you are urged to participate in the rule hearing process.

PLEASE NOTE, HOWEVER, THAT THE HEARING WILL BE CANCELLED IF FEWER THAN TWENTY-FIVE PERSONS REQUEST A HEARING IN RESPONSE TO THE NOTICE OF INTENT TO ADOPT THESE SAME RULES WITHOUT A PUBLIC HEARING PUBLISHED IN THIS STATE REGISTER AND MAILED TO PERSONS REGISTERED WITH THE DEPARTMENT OF HUMAN SERVICES. To verify whether a hearing will be held, please call the Department of Human Services between September 20, 1990 and September 28, 1990 at (612) 297 4301.

Following the agency's presentation at the hearing, all interested or affected persons will have an opportunity to participate. Such persons may present their views either orally at the hearing or in writing at any time prior to the close of the hearing record. All evidence presented should be pertinent to the matter at hand. Written material not submitted at the time of the hearing which is to be included in the hearing record may be mailed to Aministrative Law Judge Peter C. Erickson, 500 Flour Exchange Building, 310 Fourth Avenue South, Minneapolis, Minnesota 55415; telephone (612) 341-7606, either before the hearing or within five working days after the public hearing ends. The Administrative Law Judge may at the hearing, order the record be kept open for a longer period not to exceed 20 calendar days. The comments received during the comment period shall be available for review at the Office of Administrative Hearings. Following the close of the comment period the agency and all interested persons have three business days to respond in writing to any new information submitted during the comment period. During the three-day period, the agency may indicate in writing whether there are amendments suggested by other persons which the agency is willing to adopt. No additional evidence may be submitted during the three-day period. The written responses shall be added to the rulemaking record. Upon the close of the record the Administrative Law Judge will write a report as provided for in

Minnesota Statutes, sections 14.15 and 14.50. The rule hearing is governed by Minnesota Statutes, sections 14.14 to 14.20 and by Minnesota Rules, parts 1400.0200 to 1400.1200. Questions about procedure may be directed to the Administrative Law Judge.

Parts 9505.3500 to 9505.3700 establish the standards and procedures applicable to community alternative care (CAC) services available under a waiver from the Health Care Financing Administration to chronically ill individuals who are hospitalized or who require frequent hospitalization, who are eligible to receive medical assistance, and who meet the eligibility requirements specified in the rules. The proposed rules will specify: 1. the home and community-based services availble under CAC; 2. conditions of eligibility for CAC; 3. the procedures for requesting CAC and determining eligibility for CAC; 4. the duties of the case manager and interdisciplinary team in assessing the CAC applicant's or recipient's health and needed health services; 5. the development and contents of a care plan for the CAC applicant or recipient; 6. conditions for termination from eligibility for CAC services; 7. standards for the following CAC services authorized under the waiver from the Health Care Financing Administration: home health, homemaker, respite care, counseling and training, environmental modifications in the home, medical equipment, medical transportation, therapy, foster care; 8. local agency responsibilities, including the designation of a lead agency to administer the county's CAC program; 9. the method of calculating a parental or spousal financial contribution toward the cost of CAC services; 10. criteria for and method of selecting CAC service providers and the duties of the providers; 11. the maximum CAC service rates and their annual adjustment to be made by the commissioner; 12. the commissioner's responsibility to determine an applicant's eligibility for CAC; 13. the annual dollar limits that may be expended from medical assistance and CAC funds for health services to a recipient and to all Minnesota CAC recipients; and 14. actions related to CAC application and services that are appealable and the appeal process.

The agency's authority to adopt the proposed rules is contained in Minnesota Statutes, section 256B.49.

Adoption of these rules will not result in additional spending by local public bodies in excess of $100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section 14.11.

Copies of the proposed rules are now available and at least one free copy may be obtained by writing to:

Nancy Bishop
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816.

This rule is also available for viewing at each of the county welfare or human service agencies in the State of Minnesota.

Additional copies will be available at the hearing. If you have any questions on the content of the rule contact Eleanor Weber at (612) 297 4301.

NOTICE: Any person may request notification of the date on which the Administrative Law Judge's report will be available, after which date the agency may not take any final action on the rules for a period of five working days. If you desire to be notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the Administrative Law Judge. Any person may request notification of the date on which the rules were adopted and filed with the secretary of state. The notice must be mailed on the same day the rules are filed. If you want to be so notified you may so indicate at the hearing or send a request in writing to the agency at any time prior to the filing of the rules with the secretary of state.

NOTICE IS HEREBY GIVEN that a Statement of Need and Reasonableness is now available for review at the agency and at the Office of Administrative Hearings. The Statement of Need and Reasonableness includes a summary of all the evidence and argument which the agency anticipates presenting at the hearing justifying both the need for and reasonableness of the proposed rules. Copies of the Statement of Need and Reasonableness may be reviewed at the agency or the Office of Administrative Hearings and copies may be obtained from the Office of Administrative Hearings at the cost of reproduction.

Minnesota Statutes, chapter 10A, requires each lobbyist to register with the State Ethical Practices Board within five days after he or she commences lobbying. A lobbyist is defined in Minnesota Statutes, section 10A.01, subdivision 11, as any individual:

(a) engaged for pay or other consideration, or authorized by another individual or association to spend money, who spends more than five hours in any month or more than $250, not including travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communication or urging others to communicate with public officials; or

(b) who spends more than $250, not including traveling expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials.

The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 625 North Robert Street, St. Paul, Minnesota 55101, telephone (612) 296-5148.

Dated: 7-31-90

ANN WYNIA
Commissioner

RECEIVED
90 SEP -6 AM 11:52
ADMINISTRATIVE
HEARINGS

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Amendment of Department of Human Services Rules Governing Community Alternative Care for Chronically Ill Individuals, Minnesota Rules, Parts 9505.3500 to 9505.3700

AFFIDAVIT OF ADDITIONAL MAILING

Joyce Pederson, being first duly sworn, deposes and says:

That on the 15th day of August, 1990, at the City of St. Paul, County of Ramsey, State of Minnesota, I mailed the attached Notice by depositing in the State of Minnesota Central Mail System for first class mailing, a copy thereof, properly enveloped, with postage prepaid to the following parties:

- The 87 Minnesota County Human Services Agencies
- 222 PHN Services and Home Health Care Centers
- 17 Advisory Committee Members

Joyce Pederson

Subscribed and sworn to before me
this 15 day of August, 1990
Claudia A. Eliason

CLAUDIA A. ELIASON
NOTARY PUBLIC-MINNESOTA
WASHINGTON COUNTY
MY COMMISSION EXPIRES NOVEMBER 15, 1990

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Amendment of Department of Human Services Rules Governing Community Alternative Care for Chronically Ill Individuals, Minnesota Rules, parts 9505.3500 to 9505.3700.	NOTICE OF HEARING AND NOTICE OF INTENT TO CANCEL HEARING IF FEWER THAN TWENTY-FIVE PERSONS REQUEST A HEARING IN RESPONSE TO NOTICE OF INTENT TO ADOPT RULES WITHOUT A PUBLIC HEARING

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PLEASE NOTE, HOWEVER, THAT THE HEARING WILL BE CANCELLED IF FEWER THAN TWENTY-FIVE PERSONS REQUEST A HEARING IN RESPONSE TO THE NOTICE OF INTENT TO ADOPT THESE SAME RULES WITHOUT A PUBLIC HEARING PUBLISHED IN THIS STATE REGISTER AND MAILED TO PERSONS REGISTERED WITH THE DEPARTMENT OF HUMAN SERVICES. To verify whether a hearing will be held, please call the Department of Human Services between September 20, 1990 and September 28, 1990 at (612) 297 4301.

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The agency's authority to adopt the proposed rules is contained in Minnesota Statutes, section 256B.49.

Adoption of these rules will not result in additional spending by local public bodies in excess of $100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section 14.11.

Copies of the proposed rules are now available and at least one free copy may be obtained by writing to:

Nancy Bishop
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816.

This rule is also available for viewing at each of the county welfare or human service agencies in the State of Minnesota.

Additional copies will be available at the hearing. If you have any questions on the content of the rule contact Eleanor Weber at (612) 297 4301.

NOTICE: Any person may request notification of the date on which the Administrative Law Judge's report will be available, after which date the agency may not take any final action on the rules for a period of five working days. If you desire to be notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the Administrative Law Judge. Any person may request notification of the date on which the rules were adopted and filed with the secretary of state. The notice must be mailed on the same day the rules are filed. If you want to be so notified you may so indicate at the hearing or send a request in writing to the agency at any time prior to the filing of the rules with the secretary of state.

NOTICE IS HEREBY GIVEN that a Statement of Need and Reasonableness is now available for review at the agency and at the Office of Administrative Hearings. The Statement of Need and Reasonableness includes a summary of all the evidence and argument which the agency anticipates presenting at the hearing justifying both the need for and reasonableness of the proposed rules. Copies of the Statement of Need and Reasonableness may be reviewed at the agency or the Office of Administrative Hearings and copies may be obtained from the Office of Administrative Hearings at the cost of reproduction.

Minnesota Statutes, chapter 10A, requires each lobbyist to register with the State Ethical Practices Board within five days after he or she commences lobbying. A lobbyist is defined in Minnesota Statutes, section 10A.01, subdivision 11, as any individual:

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(b) who spends more than $250, not including traveling expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials.

The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 625 North Robert Street, St. Paul, Minnesota 55101, telephone (612) 296-5148.

Dated: 7-31-90

ANN WYNIA
Commissioner

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Amendment of Rules of the State Department of Human Services Governing Community Alternative Care for Chronically Ill Individuals, Minnesota Rules, parts 9505.3500 to 9505.3700.	NOTICE OF INTENT TO ADOPT A RULE WITHOUT A PUBLIC HEARING AND NOTICE OF INTENT TO ADOPT A RULE WITH A PUBLIC HEARING IF TWENTY-FIVE OR MORE PERSONS REQUEST A HEARING

Notice is hereby given that the State Department of Human Services proposes to adopt the above-entitled rule without a public hearing following the procedures set forth in Minnesota Statutes, section 14.22 to 14.28. The specific statutory authority to adopt the rule is Minnesota Statutes, section 256B.49.

Persons interested in this rule shall have 30 days in which to submit comment in support of or in opposition to the proposed rule or any part or subpart of the rule and comment is encouraged. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to Minnesota Statutes, section 14.131 to 14.20. PLEASE NOTE THAT IF TWENTY-FIVE OR MORE PERSONS SUBMIT WRITTEN REQUESTS FOR A PUBLIC HEARING WITHIN THE 30-DAY COMMENT PERIOD, A HEARING WILL BE HELD ON Monday, October 1, 1990, UNLESS A SUFFICIENT NUMBER WITHDRAW THEIR REQUEST, IN ACCORDANCE WITH THE NOTICE OF PUBLIC HEARING ON THESE SAME RULES PUBLISHED IN THIS STATE REGISTER AND MAILED TO PERSONS REGISTERED WITH THE DEPARTMENT OF HUMAN SERVICES. To verify whether a hearing will be held, please call the Department of Human Services between September 20, 1990 and September 28, 1990 at (612) 297 4301.

Persons who wish to submit comments or a written request for a public hearing must submit such comments or requests to:

Eleanor Weber
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816

Comments or requests for a public hearing must be received by the Department by 4:30 p.m. on Wednesday, September 19, 1990.

The proposed rule may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed rule as noticed.

A free copy of this rule is available upon request for your review from:

Nancy Bishop
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816
(612) 296 7454.

A copy of the proposed rule may be viewed at any of the county welfare or human service agencies in the State of Minnesota.

Parts 9505.3500 to 9505.3700 establish the standards and procedures applicable to community alternative care (CAC) services available under a waiver from the Health Care Financing Administration to chronically ill individuals who are hospitalized or who require frequent hospitalization, who are eligible to receive medical assistance, and who meet the eligibility requirements specified in the rules. The proposed rules will specify: 1. the home and community-based services available under CAC; 2. conditions of eligibility for CAC; 3. the procedures for requesting CAC and determining eligibility for CAC; 4. the duties of the case manager and interdisciplinary team in assessing the CAC applicant's or recipient's health and needed health services and in recommending the health services needed; 5. the development and contents of a care plan for the CAC applicant or recipient; 6. conditions for termination from eligibility for CAC services; 7. standards for the following CAC services authorized under the waiver from the Health Care Financing Administration: home health, homemaker, respite care, counseling and training, environmental modifications in the home, medical equipment, medical transportation, therapy, foster care; 8. local agency responsibilities, including the designation of a lead agency to administer the county's CAC program; 9. the method of calculating a parental or spousal financial contribution toward the cost of CAC services; 10. criteria for and method of selecting a CAC service provider and the duties of the providers; 11. the maximum CAC services rates and their annual adjustment to be made by the commissioner; 12. the commissioner's responsibility to determine an applicant's eligibility for CAC; 13. the annual dollar limits that may be expended from medical assistance and CAC funds for health services to a recipient and to all Minnesota CAC recipients; and 14. actions related to CAC applications and services that are appealable and the appeal process.

A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the

proposed rule has been prepared and is available upon request from:

Nancy Bishop
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816
(612) 296 7454.

Adoption of these rules will not result in additional spending by local public bodies in the excess of $100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section 14.11.

If no hearing is required upon adoption of the rule, the rule and the required supporting documents will be delivered to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to:

Eleanor Weber
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816.

State of Minnesota

Dated: 7-31-90

ANN WYNIA
Commissioner

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STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Amendment of the Department of Human Services Rules Governing Community Alternative Care for Chronically Ill Individuals, Minnesota Rules, Parts 9505.3500 to 9505.3700

CERTIFICATE

I hereby certify that the list of persons, associations and other interested groups who have requested, pursuant to Minnesota Statutes, section 14.14, subdivision 1a, and 14.22 or 14.30, that their names be placed on the State Department of Human Services rulemaking mailing list is accurate, complete, and current as of this 15th day of August, 1990.

Joyce Pederson

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Amendment of Rules of the State Department of Human Services Governing Community Alternative Care for Chronically Ill Individuals, Minnesota Rules, Parts 9505.3500 to 9505.3700

AFFIDAVIT OF MAILING THE NOTICE OF INTENT TO ADOPT A RULE WITHOUT A PUBLIC HEARING

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

Joyce Pederson, being sworn says:

I hereby certify that the list of persons and associations who have requested, pursuant to Minnesota Statutes, sections 14.14, subdivision 1a and 14.22 or 14.30, that their names be placed on the State Department of Human Services rulemaking mailing list which is accurate, complete, and current as of this 15th day of August, 1990.

That on the 15th day of August, 1990, at the City of St. Paul, County of Ramsey, State of Minnesota, I mailed the attached Notice of Intent to Adopt a Rule without a Public Hearing by depositing in the State of Minnesota Central Mail System for United States mailing, a copy thereof, with postage prepaid, to all persons and associations on the aforementioned mailing list.

Joyce Pederson

Subscribed and sworn to before me this 15 day of August, 1990.

Claudia G. Eliason

CLAUDIA A. ELIASON
NOTARY PUBLIC-MINNESOTA
WASHINGTON COUNTY
MY COMMISSION EXPIRES NOVEMBER 15, 1990

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Amendment of Department of Human Services Rules Governing Community Alternative Care for Chronically Ill Individuals, Minnesota Rules, parts 9505.3500 to 9505.3700.	NOTICE OF HEARING AND NOTICE OF INTENT TO CANCEL HEARING IF FEWER THAN TWENTY-FIVE PERSONS REQUEST A HEARING IN RESPONSE TO NOTICE OF INTENT TO ADOPT RULES WITHOUT A PUBLIC HEARING

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Dated: 7-31-90

ANN WYNIA
Commissioner

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Amendment of Rules of the State Department of Human Services Governing Community Alternative Care for Chronically Ill Individuals, Minnesota Rules, parts 9505.3500 to 9505.3700.

NOTICE OF INTENT TO ADOPT A RULE WITHOUT A PUBLIC HEARING AND NOTICE OF INTENT TO ADOPT A RULE WITH A PUBLIC HEARING IF TWENTY-FIVE OR MORE PERSONS REQUEST A HEARING

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St. Paul, MN 55155-3816

Comments or requests for a public hearing must be received by the Department by 4:30 p.m. on Wednesday, September 19, 1990.

The proposed rule may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed rule as noticed.

A free copy of this rule is available upon request for your review from:

Nancy Bishop
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816
(612) 296 7454.

A copy of the proposed rule may be viewed at any of the county welfare or human service agencies in the State of Minnesota.

Parts 9505.3500 to 9505.3700 establish the standards and procedures applicable to community alternative care (CAC) services available under a waiver from the Health Care Financing Administration to chronically ill individuals who are hospitalized or who require frequent hospitalization, who are eligible to receive medical assistance, and who meet the eligibility requirements specified in the rules. The proposed rules will specify: 1. the home and community-based services available under CAC; 2. conditions of eligibility for CAC; 3. the procedures for requesting CAC and determining eligibility for CAC; 4. the duties of the case manager and interdisciplinary team in assessing the CAC applicant's or recipient's health and needed health services and in recommending the health services needed; 5. the development and contents of a care plan for the CAC applicant or recipient; 6. conditions for termination from eligibility for CAC services; 7. standards for the following CAC services authorized under the waiver from the Health Care Financing Administration: home health, homemaker, respite care, counseling and training, environmental modifications in the home, medical equipment, medical transportation, therapy, foster care; 8. local agency responsibilities, including the designation of a lead agency to administer the county's CAC program; 9. the method of calculating a parental or spousal financial contribution toward the cost of CAC services; 10. criteria for and method of selecting a CAC service provider and the duties of the providers; 11. the maximum CAC services rates and their annual adjustment to be made by the commissioner; 12. the commissioner's responsibility to determine an applicant's eligibility for CAC; 13. the annual dollar limits that may be expended from medical assistance and CAC funds for health services to a recipient and to all Minnesota CAC recipients; and 14. actions related to CAC applications and services that are appealable and the appeal process.

A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the

proposed rule has been prepared and is available upon request from:

Nancy Bishop
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816
(612) 296 7454.

Adoption of these rules will not result in additional spending by local public bodies in the excess of $100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section 14.11.

If no hearing is required upon adoption of the rule, the rule and the required supporting documents will be delivered to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to:

Eleanor Weber
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816.

State of Minnesota

Dated: 7-31-90

ANN WYNIA
Commissioner

Proposed Rules

RECEIVED
90 SEP -6 AM 11:53
ADMINISTRATIVE
HEARINGS

Pursuant to Minn. Stat. §§ 14.22, an agency may propose to adopt, amend, suspend or repeal rules without first holding a public hearing, as long as the agency determines that the rules will be noncontroversial in nature. The agency must first publish a notice of intent to adopt rules without a public hearing, together with the proposed rules, in the *State Register*. The notice must advise the public:

1. that they have 30 days in which to submit comment on the proposed rules;
2. that no public hearing will be held unless 25 or more persons make a written request for a hearing within the 30-day comment period;
3. of the manner in which persons shall request a hearing on the proposed rules; and
4. that the rule may be modified if the modifications are supported by the data and views submitted.

If, during the 30-day comment period, 25 or more persons submit to the agency a written request for a hearing of the proposed rules, the agency must proceed under the provisions of §§ 14.14-14.20, which state that if an agency decides to hold a public hearing, it must publish a notice of intent in the *State Register*.

Pursuant to Minn. Stat. §§ 14.29 and 14.30, agencies may propose emergency rules under certain circumstances. Proposed emergency rules are published in the *State Register* and, for at least 25 days thereafter, interested persons may submit data and views in writing to the proposing agency.

Department of Human Services

Proposed Permanent Rules Relating to Community Alternative Care Program

Notice of Intent to Adopt a Rule Without a Public Hearing and Notice of Intent to Adopt a Rule With a Public Hearing If Twenty-Five or More Persons Request a Hearing

NOTICE IS HEREBY GIVEN that the State Department of Human Services proposes to adopt the above-entitled rule without a public hearing following the procedures set forth in *Minnesota Statutes*, section 14.22 to 14.28. The specific statutory authority to adopt the rule is *Minnesota Statutes*, section 256B.49.

Persons interested in this rule shall have 30 days in which to submit comment in support of or in opposition to the proposed rule or any part or subpart of the rule and comment is encouraged. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to *Minnesota Statutes*, section 14.131 to 14.20. **PLEASE NOTE that if twenty-five or more persons submit written requests for a public hearing within the 30-day comment period, a hearing will be held on Monday, October 1, 1990, unless a sufficient number withdraw their request, in accordance with the notice of public hearing on these same rules published in this *State Register* and mailed to persons registered with the Department of Human Services.** To verify whether a hearing will be held, please call the Department of Human Services between September 20, 1990 and September 28, 1990 at (612) 297-4301.

Persons who wish to submit comments or a written request for a public hearing must submit such comments or requests to:

Eleanor Weber
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816

Comments or requests for a public hearing must be received by the Department by 4:30 p.m. on Wednesday, September 19, 1990.

The proposed rule may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed rule as noticed.

A free copy of this rule is available upon request for your review from:

Nancy Bishop
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816
(612) 296-7454

A copy of the proposed rule may be viewed at any of the county welfare or human service agencies in the State of Minnesota.

Parts 9505.3500 to 9505.3700 establish the standards and procedures applicable to community alternative care (CAC) services available under a waiver from the Health Care Financing Administration to chronically ill individuals who are hospitalized or who require frequent hospitalization, who are eligible to receive medical assistance, and who meet the eligibility requirements specified in the rules. The proposed rules will specify: 1. the home and community-based services available under CAC; 2. conditions of eligibility for CAC; 3. the procedures for requesting CAC and determining eligibility for CAC; 4. the duties of the case manager and interdisciplinary team in assessing the CAC applicant's or recipient's health and needed health services and in recommending the health services needed; 5. the development and contents of a care plan for the CAC applicant or recipient; 6. conditions for termination from eligibility for CAC services; 7. standards for the following CAC services authorized under the waiver from the Health Care Financing Administration: home health, homemaker, respite care, counseling and training, environmental modifications in the home, medical equipment, medical transportation, therapy, foster care; 8. local agency responsibilities, including the designation of a lead agency to administer the county's CAC program; 9. the method of calculating a paternal or spousal financial contribution toward the cost of CAC services; 10. criteria for and method of selecting a CAC service provider and the duties of the providers; 11. the maximum CAC services rates and their annual adjustment to be made by the commissioner; 12. the commissioner's responsibility to determine an applicant's eligibility for CAC; 13. the annual dollar limits that may be expended from medical assistance and CAC funds for health services to a recipient and to all Minnesota CAC recipients; and 14. actions related to CAC applications and services that are appealable and the appeal process.

A STATEMENT OF NEED AND REASONABLENESS that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the proposed rule has been prepared and is available upon request from:

Nancy Bishop
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816
(612) 296-7454

Adoption of these rules will not result in additional spending by local public bodies in the excess of $100,000 per year for the first two years following adoption under the requirements of *Minnesota Statutes*, section 14.11.

If no hearing is required upon adoption of the rule, the rule and the required supporting documents will be delivered to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to:

Eleanor Weber
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816

State of Minnesota

Ann Wynia
Commissioner

Notice of Hearing and Notice of Intent to Cancel Hearing If Fewer Than Twenty-Five Persons Request a Hearing in Response to Notice of Intent to Adopt Rules Without a Public Hearing

NOTICE IS HEREBY GIVEN that a public hearing on the above-entitled matter will be held in the Department of Human Services, in Room 1B, 444 Lafayette Road, St. Paul, MN 55155 on Monday, October 1, 1990 commencing at 9:00 a.m. and continuing until all interested or affected persons have an opportunity to participate. The proposed rules may be modified as a result of the hearing process. Therefore, if you are affected in any manner by the proposed rules, you are urged to participate in the rule hearing process.

PLEASE NOTE, however, that the hearing will be cancelled if fewer than twenty-five persons request a hearing in response to the notice of intent to adopt these same rules without a public hearing published in this *State Register* and mailed to persons registered with the Department of Human Services. To verify whether a hearing will be held, please call the Department of Human Services between September 20, 1990 and September 28, 1990 at (612) 297-4301.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." **ADOPTED RULES SECTION** — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

Following the agency's presentation at the hearing, all interested or affected persons will have an opportunity to participate. Such persons may present their views either orally at the hearing or in writing at any time prior to the close of the hearing record. All evidence presented should be pertinent to the matter at hand. Written material not submitted at the time of the hearing which is to be included in the hearing record may be mailed to Administrative Law Judge Peter C. Erickson, 500 Flour Exchange Building, 310 Fourth Avenue South, Minneapolis, Minnesota 55415; telephone (612) 341-7606, either before the hearing or within five working days after the public hearing ends. The Administrative Law Judge may at the hearing, order the record be kept open for a longer period not exceed 20 calendar days. The comments received during the comment period shall be available for review at the Office of Administrative Hearings. Following the close of the comment period the agency and all interested persons have three business days to respond in writing to any new information submitted during the comment period. During the three-day period, the agency may indicate in writing whether there are amendments suggested by other persons which the agency is willing to adopt. No additional evidence may be submitted during the three-day period. The written responses shall be added to the rulemaking record. Upon the close of the record the Administrative Law Judge will write a report as provided for in *Minnesota Statutes*, sections 14.15 and 14.50. The rule hearing is governed by *Minnesota Statutes*, sections 14.14 to 14.20 and by *Minnesota Rules*, parts 1400.0200 to 1400.1200. Questions about procedure may be directed to the Administrative Law Judge.

Parts 9505.3500 to 9505.3700 establish the standards and procedures applicable to community alternative care (CAC) services available under a waiver from the Health Care Financing Administration to chronically ill individuals who are hospitalized or who require frequent hospitalization, who are eligible to receive medical assistance, and who meet the eligibility requirements specified in the rules. The proposed rules will specify: 1. the home and community-based services available under CAC; 2. conditions of eligibility for CAC; 3. the procedures for requesting CAC and determining eligibility for CAC; 4. the duties of the case manager and interdisciplinary team in assessing the CAC applicant's or recipient's health and needed health services; 5. the development and contents of a care plan for the CAC applicant or recipient; 6. conditions for termination from eligibility for CAC services; 7. standards for the following CAC services authorized under the waiver from the Health Care Financing Administration: home health, homemaker, respite care, counseling and training, environmental modifications in the home, medical equipment, medical transportation, therapy, foster care; 8. local agency responsibilities, including the designation of a lead agency to administer the county's CAC program; 9. the method of calculating a parental or spousal financial contribution toward the cost of CAC services; 10. criteria for and method of selecting CAC service providers and the duties of the providers; 11. the maximum CAC service rates and their annual adjustment to be made by the commissioner; 12. the commissioner's responsibility to determine an applicant's eligibility for CAC; 13. the annual dollar limits that may be expended from medical assistance and CAC funds for health services to a recipient and to all Minnesota CAC recipients; and 14. actions related to CAC application and services that are appealable and the appeal process.

The agency's authority to adopt the proposed rules is contained in *Minnesota Statutes*, section 256B.49.

Adoption of these rules will not result in additional spending by local public bodies in excess of $100,000 per year for the first two years following adoption under the requirements of *Minnesota Statutes*, section 14.11.

Copies of the proposed rules are now available and at least one free copy may be obtained by writing to:

Nancy Bishop
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816

This rule is also available for viewing at each of the county welfare or human service agencies in the State of Minnesota.

Additional copies will be available at the hearing. If you have any questions on the content of the rule contact Eleanor Weber at (612) 297-4301.

NOTICE: Any person may request notification of the date on which the Administrative Law Judge's report will be available, after which date the agency may not take any final action on the rules for a period of five working days. If you desire to be notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the Administrative Law Judge. Any person may request notification of the date on which the rules were adopted and filed with the secretary of state. The notice must be mailed on the same day the rules are filed. If you want to be so notified you may so indicate at the hearing or send a request in writing to the agency at any time prior to the filing of the rules with the secretary of state.

NOTICE IS HEREBY GIVEN that a Statement of Need and Reasonableness is now available for review at the agency and at the Office of Administrative Hearings. The Statement of Need and Reasonableness includes a summary of all the evidence and argument which the agency anticipates presenting at the hearing justifying both the need for and reasonableness of the proposed rules. Copies of the Statement of Need and Reasonableness may be reviewed at the agency or the Office of Administrative Hearings and copies may be obtained from the Office of Administrative Hearings at the cost of reproduction.

Minnesota Statutes, chapter 10A, requires each lobbyist to register with the State Ethical Practices Board within five days after he or she commences lobbying. A lobbyist is defined in *Minnesota Statutes*, section 10A.01, subdivision 11, as any individual:

(a) engaged for pay or other consideration, or authorized by another individual or association to spend money, who spends more than five hours in any month or more than $250, not including travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communication or urging others to communicate with public officials; or

(b) who spends more than $250, not including traveling expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials.

The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 625 North Robert Street, St. Paul, Minnesota 55101, telephone (612) 296-5148.

Ann Wynia
Commissioner

Rules as Proposed (all new material)

COMMUNITY ALTERNATIVE CARE PROGRAM

9505.3500 APPLICABILITY AND EFFECT.

Subpart 1. **Applicability.** Parts 9505.3500 to 9505.3700 establish standards and procedures applicable to the community alternative care (CAC) program. Individuals who are eligible for and receiving medical assistance services may also be eligible for and receive services under the community alternative care program. CAC pays for approved home and community-based services in lieu of hospital admission or continued hospitalization for individuals who meet the requirements of parts 9505.3500 to 9505.3700, *Minnesota Statutes*, section 256B.49, and the Code of Federal Regulations, title 42, section 441.302(e)(2). Parts 9505.3500 to 9505.3700 must be read in conjunction with *Minnesota Statutes*, chapter 256B; parts 9500.1070, subparts 1 and 12 to 15; 9500.1090 to 9500.1155; chapter 9505; Title XIX of the Social Security Act; and title 42 of the Code of Federal Regulations; and the requirements of the waiver obtained by the state from the United States Department of Health and Human Services.

Parts 9505.3500 to 9505.3700 apply to local agencies administering medical assistance funds and providing case management services; entities and organizations contracting to perform functions under *Minnesota Statutes*, 256B.49; providers of home and community-based services who are paid or who request payment under parts 9505.3500 to 9505.3700; and CAC applicants and recipients.

Subp. 2. **Effect.** References to the waiver and waiver provisions that occur in parts 9505.3500 to 9505.3700 shall continue in effect only as long as the waiver from the United States Department of Health and Human Services is in effect in Minnesota.

9505.3510 DEFINITIONS.

Subpart 1. **Applicability.** The definitions in this part apply to parts 9505.3500 to 9505.3700.

Subp. 2. **Acting case manager.** "Acting case manager" means a person who is a public health nurse, medical social worker, county social worker, or registered nurse who is appointed by the department and performs case management services specified in subpart 6 for an applicant until the applicant's eligibility for CAC services is determined and a case manager is assigned.

Subp. 3. **Applicant.** "Applicant" means an individual who has submitted an application to participate in the CAC program rather than reside in a hospital or remain at risk of frequent hospitalization.

Subp. 4. **Application.** "Application" means an application to participate in CAC that is completed according to part 9505.3540.

Subp. 5. **Assessment.** "Assessment" means the process an interdisciplinary team uses to identify an applicant's health service needs according to part 9505.3540 so that the team can determine the appropriateness of home and community-based services in meeting the applicant's needs.

Subp. 6. **Case management services.** "Case management services" means services in which a case manager identifies, arranges, authorizes, and coordinates health services including home and community-based services under parts 9505.3500 to 9505.3700 for a recipient; monitors the delivery of services; adjusts services to the needs of the recipient; and advocates for the rights of the recipient.

Subp. 7. **Case manager.** "Case manager" means a social worker, registered nurse, or public health nurse who is employed by or under contract with the lead agency and who performs case management services.

Subp. 8. **Chronically ill individual or individual.** "Chronically ill individual" or "individual" means an individual who needs an extensive array of health services for an undetermined period of time, whose health condition requires frequent monitoring and

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treatment by a health care professional or by a person supervised by a health care professional, and who would reside in a hospital or require frequent hospitalization if these services were not provided.

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

Subp. 10. **Community alternative care program or CAC.** "Community alternative care program" or "CAC" means the program specified in the Minnesota Medicaid model waiver approved by the United States Department of Health and Human Services to provide home and community-based services to chronically ill individuals under age 65.

Subp. 10a. **Counseling and training services.** "Counseling and training services" means counseling and training approved by the case manager for primary caregivers in issues pertaining to the maintenance of the recipient in the home. Examples of counseling are crisis counseling and family or individual counseling as required for family functioning. An example of training is teaching a family member or other primary caregiver a treatment regimen or how to use medical equipment.

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 that performs or arranges services for recipients under parts 9505.3500 to 9505.3700. County of service may be either the county of financial responsibility or the county in which the recipient resides.

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

Subp. 14. **Durable medical equipment.** "Durable medical equipment" means a device that can withstand repeated use, is provided to correct or accommodate a physiological disorder or physical condition, and is suitable for use in the recipient's residence.

Subp. 15. **Environmental modifications in the home.** "Environmental modifications to the home" means structural changes to a recipient's residence that are prescribed in the recipient's care plan and that are necessary to maintain the recipient in the recipient's home. Examples of environmental modifications are changes in electrical wiring to accommodate equipment, construction of wheelchair ramps, and widening of doors.

Subp. 16. **Foster care services.** "Foster care services" means ongoing residential care and supportive services provided to a recipient living in a foster home licensed under parts 9545.0010 to 9545.0260; or 9555.5105 to 9555.6265.

Subp. 17. **Health care professional.** "Health care professional" means a physician, registered nurse, licensed practical nurse, occupational therapist, physical therapist, respiratory therapist, or a speech-language pathologist.

Subp. 18. **Health service.** "Health service" means a medically necessary service that is ordered by a physician, documented in an approved care plan, and provided to a recipient as ordered in the care plan. The term includes home and community-based services and services provided under parts 9505.0170 to 9505.0475.

Subp. 19. **Home.** "Home" means the recipient's residence as defined in part 9505.0175, subpart 43. "Home" does not include a hospital or long-term care facility.

Subp. 20. **Home and community-based services.** "Home and community-based services" means the services listed in items A to L that are available under the waiver to recipients:

A. case management services under part 9505.3560;

B. home health services under part 9505.3570;

C. homemaker services under part 9505.3575;

D. respite care services under part 9505.3580;

E. physician services under part 9505.3585;

F. family counseling and training under part 9505.3600;

G. environmental modifications in the home under part 9505.3610;

H. medical equipment under part 9505.3620;

I. medical transportation under part 9505.3622;

J. prescribed drugs under part 9505.3624;

K. other professional services under part 9505.3626; and

L. foster care services under part 9505.3630.

Subp. 21. **Home care plan or care plan.** "Home care plan" or "care plan" means the written plan of health services provided to a recipient that are necessary to maintain a recipient in the recipient's home.

Subp. 22. **Home health aide.** "Home health aide" means a person who meets the standards for a home health aide in part 9505.0290, subpart 3.

Subp. 23. **Homemaker.** "Homemaker" means a person who provides homemaker services and is qualified according to part 9565.1200, subpart 2.

Subp. 24. **Homemaker services.** "Homemaker services" means the activities specified in parts 9565.1100 and 9565.1200 that are prescribed in the recipient's care plan and provided by a homemaker.

Subp. 25. **Hospital.** "Hospital" has the meaning given in *Minnesota Statutes*, section 144.696, subdivision 3.

Subp. 26. **Interdisciplinary team or team.** "Interdisciplinary team" or "team" means a team specified in part 9505.3535 that is responsible for developing a home care plan for an applicant or for a recipient.

Subp. 27. **Lead agency.** "Lead agency" means the county welfare department or public health agency designated by the local agency to administer CAC.

Subp. 28. **Licensed practical nurse.** "Licensed practical nurse" means a person licensed under and providing health services within the scope of *Minnesota Statutes*, section 148.29.

Subp. 29. **Local agency.** "Local agency" means the county or multicounty agency that is authorized under *Minnesota Statutes*, section 256B.05 to administer the medical assistance program, including the community alternative care program.

Subp. 30. **Medical assistance.** "Medical assistance" means the program established under title XIX of the Social Security Act and *Minnesota Statutes*, chapter 256B.

Subp. 31. **Medical social worker.** "Medical social worker" means a graduate of a school of social work accredited by the Council on Social Work Education who has had social work experience in a hospital, outpatient clinic, medical rehabilitation, or medical care program.

Subp. 32. **Medically necessary.** "Medically necessary" has the meaning given in part 9505.0175, subpart 25.

Subp. 33. **Nondurable medical equipment.** "Nondurable medical equipment" means a supply or piece of equipment that is used to treat a health condition and that cannot be reused.

Subp. 34. **Nursing services.** "Nursing services" means services ordered by a physician, specified in the recipient's care plan, and provided by a licensed practical nurse or provided by a registered nurse or provided under the supervision of a registered nurse.

Subp. 35. **Nutritionist.** "Nutritionist" means a person who at a minimum has a bachelor's degree in nutrition and foods or a closely related field and is registered as a dietitian with the Commission of Dietetic Registration.

Subp. 36. **Occupational therapist.** "Occupational therapist" means a person who is currently registered as an occupational therapist with the American Occupational Therapy Association or who is a graduate of a program in occupational therapy approved by the Council of Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association and who is acquiring the supervised clinical experience prerequisite to registration by the American Occupational Therapy Association.

Subp. 37. **Physical therapist.** "Physical therapist" means a person holding a current Minnesota certificate of registration as a physical therapist.

Subp. 38. **Physician.** "Physician" means a person who is licensed to provide health services within the scope of the physician's profession under *Minnesota Statutes*, chapter 147.

Subp. 39. **Prescribed drug.** "Prescribed drug" means a drug as defined in *Minnesota Statutes*, section 151.01, subdivision 5, ordered by the recipient's physician, and specified in the recipient's care plan.

Subp. 40. **Primary caregiver.** "Primary caregiver" means the person designated by the individual as having the main role in providing informal care to the individual. Primary caregiver includes a family member, relative, friend, neighbor, and other person, who agrees to provide routine care and assistance to the recipient without reimbursement for the services and who cooperates with the case manager and other providers in assuring that services specified in the recipient's care plan are provided.

Subp. 41. **Provider.** "Provider" means a vendor who has an agreement or contract with the lead agency to provide a home and community-based service as specified in subpart 20.

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Subp. 42. **Public health nurse.** "Public health nurse" means a registered nurse certified by the Minnesota Department of Health as a public health nurse under *Minnesota Statutes*, section 145A.02, subdivision 18.

Subp. 43. **Reassessment.** "Reassessment" means the interdisciplinary team's formal redetermination of a recipient's home and community-based service needs under part 9505.3545.

Subp. 44. **Recipient.** "Recipient" means an individual determined to be eligible to receive home and community-based services under a care plan that meets the requirements of part 9505.3520 and that is approved by the commissioner under part 9505.3680.

Subp. 45. **Registered nurse.** "Registered nurse" means a person licensed under and providing services within the scope of *Minnesota Statutes*, section 148.211.

Subp. 46. **Representative.** "Representative" means a person appointed by a court as a guardian or conservator under *Minnesota Statutes*, sections 252A.01 to 252A.21, or 525.539 to 525.6198; a parent of a child under age 21 unless the parent's parental rights have been terminated; or a spouse or other person authorized by the applicant or recipient as defined in part 9505.0015, subpart 8.

Subp. 47. **Respiratory therapist.** "Respiratory therapist" means a person who is a graduate of a program in respiratory therapy approved by the Council of Medical Education of the American Medical Association in collaboration with the American Respiratory Therapy Association. If the legislature acts to require certification, registration, or licensure of respiratory therapists, "respiratory therapist" means a person certified, registered, or licensed as a respiratory therapist by the state of Minnesota.

Subp. 48. **Respite care services.** "Respite care services" means temporary supervision, assistance, and care provided to a recipient as specified in part 9505.3580 to relieve the recipient's primary caregiver, or other informal caregiver.

Subp. 49. **Social worker.** "Social worker" means an individual who meets the minimum qualifications of a social worker under the Minnesota Merit System or a county civil service system in Minnesota and who is employed as a social worker by a county.

Subp. 50. **Speech therapist or speech-language pathologist.** "Speech therapist" or "speech-language pathologist" means a person holding a current certificate from the American Speech-Language-Hearing Association in evaluation and treatment of speech-language pathologies or who has completed the academic requirements and is acquiring the supervised work experience required for certification.

Subp. 51. **Transportation.** "Transportation" means transportation that is necessary because of the recipient's health service needs, that is indicated in the recipient's care plan or is approved by the recipient's case manager, and that is not eligible for medical assistance payment under parts 9505.0010 to 9505.0475.

Subp. 52. **Waiver.** "Waiver" means the document approved by the United States Department of Health and Human Services that allows the state to exclude parental or spousal income when determining an applicant's eligibility for medical assistance and to extend services under medical assistance as specified in parts 9505.3500 to 9505.3700. The term includes all amendments to the waiver, including any amendments after the effective date of parts 9505.3500 to 9505.3700, as approved by the United States Department of Health and Human Services.

Subp. 53. **Waiver year.** "Waiver year" means April 1 to March 31.

Subp. 54. **Working day.** "Working day" means the hours of a day, excluding Saturdays, Sundays, and holidays, when a lead agency is open for business.

9505.3520 ELIGIBILITY FOR COMMUNITY ALTERNATIVE CARE SERVICES.

An individual is eligible for home and community-based services through CAC if the conditions in items A to I are met.

A. The individual is eligible for medical assistance as specified in part 9505.3640, subpart 1.

B. The individual is under 65 years of age.

C. The individual needs a home and community-based service which cannot be funded by sources other than CAC.

D. The individual has designated a primary caregiver who has been determined by a health care professional to be capable of providing specific health services to the individual in the individual's residence and has expressed a willingness to provide the specific health services according to the individual's care plan.

E. The primary physician has certified that the individual would reside in a hospital or would require frequent hospitalization without home and community-based services.

F. The anticipated average monthly cost to the medical assistance program to implement the individual's care plan, determined on a twelve-month basis, must not exceed the cost to medical assistance of providing inpatient hospital services and physician services for the individual.

G. An individual who is eligible for inpatient hospital service financial coverage by a third party payer and medical assistance is eligible for CAC services if the anticipated medical assistance payment for the CAC services is within the limit specified in item F. For purposes of this item, "third party payer" refers to Medicare and a person, entity, agency, or government program as defined in part 9505.0015, subpart 46.

H. The cost to medical assistance of CAC services specified in the individual's care plan falls within the limit specified in the waiver for the aggregate annual cost of CAC services provided under the waiver for the waiver year in which the individual is a recipient.

I. The total number of recipients to be served, including the applicant if approved, falls within the limit specified in the waiver.

9505.3530 REQUEST FOR CAC SERVICES.

Subpart 1. **Who may request service.** An individual or the representative of an individual who believes that the individual meets the criteria of part 9505.3520, items A to I may request participation in CAC according to parts 9505.3500 to 9505.3700. The request must be made to the department.

Subp. 2. **Response of department to request for CAC.** When the department receives a request for a determination of eligibility for CAC, the department shall determine which county will be the individual's county of financial responsibility and the estimated date or dates for the start of the individual's home and community-based services. The department shall designate an acting case manager and send the acting case manager the forms necessary to obtain the information required under part 9505.3540. The forms must be sent no later than five working days after receiving the request. If the acting case manager is not employed by the local agency of the applicant's county of service, the department shall notify the local agency about the request to participate in CAC and the designation of an acting case manager.

Subp. 3. **Local agency designation of team members.** No later than five working days after receiving the department's notice, the local agency of the applicant's county of service must designate a social worker and public health nurse to serve on the interdisciplinary team required under part 9505.3535.

9505.3535 INTERDISCIPLINARY TEAMS; ESTABLISHMENT AND MEMBERSHIP.

Subpart 1. **Applicant's interdisciplinary team.** No later than ten working days after being designated as an applicant's acting case manager, the acting case manager must form an interdisciplinary team. The acting case manager shall consult the applicant or, when it is appropriate, the applicant's representative in forming the team. The team must consist of at least the persons specified in items A to K.

A. the applicant or, when it is appropriate, the applicant's representative;

B. the acting case manager;

C. the applicant's physician;

D. the applicant's primary nurse;

E. in the case of an applicant who is an inpatient, a medical social worker designated by the hospital to assist in discharge planning for the applicant;

F. the county social worker designated under part 9505.3530, subpart 3;

G. the county public health nurse designated under part 9505.3530, subpart 3;

H. a representative of Services for Children with Handicaps if the applicant is under 21 years of age;

I. when it is appropriate, other persons who are expected to be the applicant's informal caregivers;

J. a representative of the local school district if the applicant is under 22 years of age; and

K. other health care professionals providing services required by the applicant's medical condition, consistent with part 9505.0190 and Code of Federal Regulations, title 42, section 431.51.

Subp. 2. **Interdisciplinary team; reconvened.** The case manager must reconvene the interdisciplinary team established under subpart 1 when a reassessment is required to determine a recipient's continued eligibility for CAC. If possible, the case manager shall assure continuity of service of team members. At a minimum, the reconvened team must include the persons specified in items A to I.

A. the recipient or, when it is appropriate, the recipient's representative;

B. the case manager;

C. the recipient's primary caregiver;

D. the recipient's physician;

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E. the county social worker designated under part 9505.3530, subpart 3;

F. the county public health nurse designated under part 9505.3530, subpart 3;

G. a representative of Services for Children with Handicaps if the recipient is under 21 years of age;

H. a representative of the local school district if the recipient is under 22 years of age; and

I. other health care professionals providing services required by the recipient's medical condition, consistent with part 9505.0190 and Code of Federal Regulations, title 42, section 431.51.

9505.3540 INTERDISCIPLINARY TEAM RESPONSIBILITIES; ASSESSMENT.

Subpart 1. **Assessment of applicant's service needs.** The team must assess the home and community-based services that an applicant will need to live in the community. The assessment must be completed on forms provided by the commissioner.

Subp. 2. **Assessment of financial resources.** The team must assess an applicant's financial resources to identify third party payers and other financial resources as defined in part 9505.0015, subpart 46, using forms provided by the commissioner.

Subp. 3. **Assessment of the applicant's home.** The team must assess the home in which the applicant lives or will live to determine if the applicant's health and safety can be assured in the residence. This assessment must be completed on forms provided by the commissioner. The assessment shall include a determination of the need for environmental modifications in the home as specified in part 9505.3610.

Subp. 4. **Assessment of person to be primary caregiver.** The team must assess the willingness and ability of the person who is expected to be the CAC applicant's primary caregiver. The team must report its assessment under this subpart on the form provided by the commissioner.

Subp. 5. **Authorization to release information.** The team must ask the applicant or the applicant's representative to sign forms that authorize the release of the applicant's medical records to the team for the assessment. A separate form supplied by the commissioner must be completed and signed for each authorization of release of information. The period of the authorization must not exceed one year. The following information must be on the form before the applicant's signature or, when it is appropriate, the signature of the applicant's representative:

A. the applicant's name;

B. the date of the authorization;

C. the information authorized;

D. the person authorized to give the information;

E. the person to whom the information is to be given;

F. a description of how the information will be used during the assessment to determine the appropriateness of CAC services; and

G. the date the authorization expires.

Subp. 6. **Rights, appeals, and freedom to choose.** The team must give the applicant or the applicant's representative written information about the applicant's rights under CAC including:

A. the right to appeal the assessment;

B. the right to choose among qualified providers of home and community-based services, consistent with part 9505.0190 and Code of Federal Regulations, title 42, section 431.51;

C. the right to confidentiality; and

D. the right to accept or reject a recommendation of the team to use home and community-based services rather than reside in a hospital.

The acting case manager must document compliance with this subpart by signing and submitting to the department forms supplied by the commissioner that state the required information was given to the applicant or, when it is appropriate, the applicant's representative.

Subp. 7. **Development of a care plan.** The interdisciplinary team shall develop a care plan for the applicant that is based on the information obtained in subparts 1 to 5. The plan must meet the requirements of subpart 8. The acting case manager must notify the department and estimate the additional time needed if the time required to complete the care plan and assessments required under this subpart exceeds the time specified in part 9505.0090, subpart 2. The applicant's care plan must be signed by the applicant or, when it is appropriate, the applicant's representative, the applicant's physician, and the acting case manager.

Subp. 8. **Contents.** The care plan developed by the interdisciplinary team for an applicant or recipient must contain at least the

information specified in items A to D. The plan must be on forms provided by the commissioner. The care plan must include all health services approved by the individual's physician regardless of the funding source or sources available to pay the cost of the health services.

A. The recommendation of the team that the applicant be approved for services funded by CAC because the applicant meets the eligibility criteria under part 9505.3520 or, in the case of a recipient, continues to be approved for services funded by CAC because the applicant continues to meet the eligibility criteria under part 9505.3520.

B. A description of the health services necessary to maintain the individual in the community, including:

(1) home and community-based services needed by the individual;

(2) qualified providers of the home and community-based services selected by the applicant or, when it is appropriate, the applicant's representative or, in the case of a recipient, by the recipient or, when it is appropriate, the recipient's representative to meet the needs identified in subitem (1);

(3) the informal caregivers who are willing and able to provide services identified in subitem (1);

(4) the required frequency of the services;

(5) the anticipated date or dates on which the applicant's services must be started;

(6) the provisions for back-up services if there is an emergency;

(7) the cost of each service;

(8) the funding source for each service; and

(9) an estimate of the total cost of all health services in the care plan including home and community-based services.

C. Documentation that the team allowed the applicant or recipient or, when it is appropriate, the representative of the applicant or recipient to choose among the available qualified providers.

D. Documentation that the applicant or recipient or, when it is appropriate, the representative of the applicant or recipient, the acting case manager or case manager, and the physician of the applicant or recipient approve the home care plan.

Subp. 9. **Team recommendation.** After completing the assessments required in subparts 1 to 4 and the care plan required in subpart 8, the interdisciplinary team must recommend one of the following:

A. that the applicant remain a hospital inpatient;

B. that the applicant be admitted to a facility from the applicant's home. For purposes of this item, "facility" means a hospital as defined in part 9505.0175, subpart 16 or a long-term care facility as defined in part 9505.0175, subpart 23; or

C. that the applicant receive health services including home and community-based services in the community.

The team's recommendation must be supported by the assessments conducted under subparts 1 to 4 and the services specified in the applicant's care plan. The applicant's physician, the acting case manager or case manager and the applicant or, when it is appropriate, the applicant's representative must sign the application.

Subp. 10. **Transmittal of plan, assessments, and recommendations to the commissioner.** The team must submit the following documents to the commissioner for a determination of the applicant's eligibility for CAC services:

A. the completed assessments required under subparts 1 to 4;

B. the documentation required under subpart 6;

C. the request for CAC services, signed by the applicant or the applicant's representative;

D. the recommendation required under subpart 9; and

E. the care plan signed by the physician, case manager, and the applicant or the applicant's representative.

9505.3545 REASSESSMENT BY INTERDISCIPLINARY TEAM.

Subpart 1. **Reassessment required.** A recipient's need and eligibility for home and community-based services must be reassessed at least once every six months. The reassessment must be carried out by an interdisciplinary team convened by the recipient's case manager as specified in part 9505.3535, subpart 2. At a minimum, the reassessment shall include the items specified in part 9505.3540,

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subparts 1 and 3 to 9. The team must review and modify the recipient's care plan as necessary and appropriate to meet the recipient's needs.

Subp. 2. **Responsibility to assure reassessment.** A local agency is responsible to assure that a recipient's reassessment is completed as required under subpart 1. If the reassessment is not completed, the local agency shall be responsible for paying the costs of the services specified in the recipient's care plan and received by the recipient until the reassessment is completed and submitted to the department.

9505.3550 RECIPIENT'S TERMINATION FROM CAC.

A recipient shall be terminated from eligibility for CAC services when:

A. the recipient chooses not to use CAC services;

B. the recipient no longer needs CAC services as determined by a reassessment;

C. the recipient's condition requires continued hospitalization for an indefinite period as certified by the recipient's physician;

D. the recipient who has been hospitalized more than 30 consecutive days in a waiver year requires home and community-based services that are not available in the community;

E. the recipient is no longer eligible for medical assistance;

F. the recipient has third party payer coverage that pays the cost of inpatient hospital services to the extent CAC services are no longer cost-effective; or

G. the recipient's condition requires health services having a cost to medical assistance that is greater than the medical assistance cost of inpatient hospital services to the recipient.

9505.3560 CASE MANAGEMENT SERVICES.

Subpart 1. **Required service.** Case management services must be provided to a recipient. The lead agency shall be responsible for implementing the case management services required under parts 9505.3500 to 9505.3700.

Subp. 2. **Designation of case manager.** No later than five working days after receiving the department's notice that an applicant's request for CAC services has been approved, the lead agency must consult with the applicant or the applicant's representative and designate a case manager. The case manager must not have a financial interest in the services provided to the applicant other than the case manager's employment by the lead agency.

Subp. 3. **Case manager responsibilities.** The case manager or, when it is appropriate, the acting case manager must:

A. convene and coordinate the interdisciplinary team;

B. gather information needed to determine an individual's eligibility for CAC under parts 9505.3500 to 9505.3700;

C. inform applicants, recipients, and their representatives about the rights specified in part 9505.3540, subpart 6 and CAC services;

D. complete and submit forms required by the commissioner under parts 9505.3500 to 9505.3700;

E. locate resources that are available to provide the services specified in the recipient's care plan;

F. coordinate and arrange services specified in the recipient's care plan;

G. seek out other home and community-based services that may contribute to the recipient's quality of life while the recipient is residing in the community but that are not reimbursable under medical assistance or CAC. Examples of other services include legal, recreational, educational, vocational, and social services;

H. meet with the recipient or the recipient's representative in the recipient's home as necessary to assure the recipient's safety and welfare and assure implementation of the recipient's services as specified in the recipient's care plan;

I. revise the care plan if the recipient's needs change between scheduled reassessments and, when it is appropriate, obtain the approval of the recipient's physician;

J. monitor costs of services to assure that the cost of the services specified in the care plan does not exceed the approved estimated cost of the care plan;

K. investigate whether the costs of the services specified in the applicant's or recipient's care plan can be met by a third party payer other than medical assistance or CAC. The case manager must document the investigation on the applicant's or recipient's care plan;

L. reconvene the interdisciplinary team at least every six months as required under part 9505.3545 or more often if necessary because of changes in the recipient's health or social needs;

M. participate in the recipient's reassessment as required under part 9505.3545 and submit the reassessment form to the department no later than ten working days after the reassessment is completed;

N. submit the care plan and revisions of the care plan to the commissioner for approval;

O. send to the department the information needed to carry out responsibilities under 9505.3680, subparts 1 and 2;

P. give notice of acceptance or rejection of an application or reduction, denial, or termination of benefits; and

Q. request the applicant, recipient, or the representative of the applicant or recipient, and the individual's physician to approve and sign the individual's care plan.

An applicant or recipient is ineligible for CAC services if the applicant or recipient or, when it is appropriate, the applicant's or recipient's representative fails to sign the care plan. The acting case manager of an applicant or the case manager of a recipient must explain to the person whose signature is being requested the consequences of failing to sign.

Subp. 4. **Case manager reports about suspected abuse of a vulnerable adult.** A case manager who has reason to believe a recipient is or has been subject to abuse or neglect as defined in *Minnesota Statutes*, section 626.557, subdivision 2, that occurs at the recipient's residence or a place where the recipient receives CAC services shall immediately comply with the reporting and other actions required under *Minnesota Statutes*, section 626.557. The case manager shall cooperate with the responsible county authority to assure the recipient's health and safety during the investigation. The case manager must request a report from the responsible county authority in order to take the action required in subpart 6.

Subp. 5. **Case manager reports about suspected abuse of a child.** A case manager who has reason to believe a recipient who is a child is or has been subject to abuse or neglect as defined in *Minnesota Statutes*, section 626.556 shall immediately report the circumstances of alleged abuse or neglect to the county authority responsible for assuring the protection of children. The case manager shall cooperate with the responsible county authority to assure the recipient's health and safety during the investigation. The case manager must request a report from the responsible county authority in order to take the action required in subpart 6.

Subp. 6. **Other actions required of case manager.** When the case manager receives the findings of the investigation carried out under subpart 4 or 5, the case manager shall determine whether a reassessment of the recipient according to part 9505.3545 is needed to amend the recipient's care plan. The case manager shall take other actions as needed to assure the recipient's health and safety, such as (1) arranging for the services of another CAC provider, (2) working out another living arrangement for the recipient or, (3) withdrawing the CAC service or services. The case manager shall forward the amended care plan to the commissioner for approval.

9505.3570 HOME HEALTH SERVICES.

Home health services established under parts 9505.0170 to 9505.0475 are available to a recipient except that the limits placed on the amount, duration, and scope of the services eligible for medical assistance payment shall be as specified in the recipient's plan of care.

9505.3575 HOMEMAKER SERVICES.

Subpart 1. **Eligibility for service.** Homemaker services are available under CAC if necessary to enable a recipient to remain in the community.

Subp. 2. **Homemaker services provider; lead agency or contractor.** The lead agency may provide directly or may contract for homemaker services that are specified in the recipient's care plan. If the lead agency directly provides homemaker services, 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.

Subp. 3. **Homemaker service standards.** The lead agency shall assure that homemaker services to a recipient are provided by the homemaker according to parts 9565.1000 to 9565.1300 and the recipient's care plan.

9505.3580 RESPITE CARE SERVICES.

Subpart 1. **Eligibility for service.** Respite care services are available under CAC if the service is necessary to maintain the recipient during a time when the primary caregiver is unable to care for the recipient. Respite care services to a recipient are limited to 720 hours per waiver year.

Subp. 2. **Provider standards.** Respite care may be provided in an out-of-home setting as specified in item A or in the recipient's home as specified in item B.

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A. Out-of-home respite care must be provided in a facility approved by the lead agency such as a hospital, nursing home, foster home, or community residential facility. When out-of-home respite care is provided, the facility must be one that meets state licensure standards.

B. A registered nurse or a public health nurse may give respite care in the recipient's home. The person providing respite care services must act in the place of the primary caregiver and shall be available to the recipient throughout the absence of the primary caregiver.

Subp. 3. **Contract required.** The lead agency shall contract with each person, facility, agency, or entity that provides respite care services. If the respite care is provided in the recipient's home, the contract must require the service to be provided as specified in subpart 2, item B. The lead agency shall monitor the contractor's compliance with the terms of the contract.

9505.3585 PHYSICIAN SERVICES.

Physician services as specified in part 9505.0345 to a CAC recipient may include home visits as necessary to maintain the recipient's safe care in the community.

9505.3600 COUNSELING AND TRAINING SERVICES.

Subpart 1. **Eligibility to receive counseling and training services.** Counseling and training services are available under CAC and shall be provided to a recipient, primary caregiver, and to members of the recipient's family with whom the recipient lives or who routinely care for the recipient. For purposes of this part, "member of the recipient's family" or "family member" refers to the recipient's parent, spouse, children, friends, relatives, foster family, or relatives-in-law. The term does not include individuals who are employed to care for the recipient.

Subp. 2. **Purpose of training.** The training must be for the purpose of increasing the ability of a primary caregiver or a member of the recipient's family to maintain and care for the recipient at home. It shall include the use of equipment and treatment regimens as specified in the recipient's care plan and training updates as may be necessary to safely maintain the recipient at home.

Subp. 3. **Purpose of counseling.** Counseling under CAC must be designed to help the recipient, the primary caregiver, and the recipient's family members handle crises related to the recipient's condition, develop coping strategies related to the recipient's daily care, and reduce stress.

Subp. 4. **Case manager approval required.** Counseling and training services under CAC must be approved by the case manager and must be specified in the recipient's care plan.

Subp. 5. **Eligibility to provide counseling and training.** A person providing counseling and training services to a recipient, a primary caregiver, or a recipient's family member must be the recipient's physician, a registered nurse, a public health nurse, a county social worker, or a medical social worker, or other qualified person as specified in the recipient's care plan and approved by the case manager. The person providing training service must determine and must document in the recipient's care plan whether a person being trained as the primary caregiver is competent to provide the services required to maintain the recipient at home.

9505.3610 ENVIRONMENTAL MODIFICATIONS IN THE HOME.

Subpart 1. **Eligibility for service.** An environmental modification in the home of a recipient is available under CAC if the modification is:

A. necessary to avoid the recipient's hospitalization;

B. approved and authorized by the recipient's case manager;

C. specified in the recipient's care plan; and

D. not available from another funding source. Examples of other funding sources are Services for Children with Handicaps and the Minnesota Housing Finance Agency.

Subp. 2. **Provider standards.** An environmental modification to the home must be completed according to all applicable state and city building codes by a provider who has been approved by the case manager. The lead agency shall specify the terms of the service to be provided in a contract or service agreement between the agency and the provider approved by the case manager. The lead agency must assure that the environmental modification in the home, when completed, meets the terms specified in the contract or service agreement between the lead agency and the provider.

9505.3620 MEDICAL EQUIPMENT.

Subpart 1. **Eligibility for medical equipment and supplies.** Medical equipment and supplies that are generally available to an individual in an institution are available under CAC for home use if:

A. the medical equipment and supplies are specified in the recipient's plan of care;

B. CAC is the only funding source available to the recipient in regard to the medical equipment and supplies; and

C. the medical equipment and supplies meet the requirements of part 9505.0310 in regard to rental, purchase, and safeguarding of recipient care.

Subp. 2. **Prior approval required.** Medical equipment and supplies require prior approval of the commissioner if:

A. they are not in the recipient's care plan approved by the commissioner under part 9505.3550;

B. they are medically necessary;

C. they exceed $25 in value per month; and

D. CAC is the only funding source for the medical equipment and supplies.

The case manager must submit to the commissioner an addendum to the recipient's care plan that documents compliance with this subpart. The commissioner shall determine whether the medical equipment and supplies meet the requirements of parts 9505.3500 to 9505.3700.

Subp. 3. **Exemption from limitation on type of equipment and supplies available.** The limitations on the types of equipment or supplies set in part 9505.0310, subpart 1, item A, and subpart 4, item A do not apply to durable medical equipment and supplies available under CAC.

9505.3622 MEDICAL TRANSPORTATION.

Transportation of a recipient for medical purposes is available under CAC if the transportation is specified in the recipient's care plan to provide access to a medically necessary service and if the transportation lies outside the scope of the local agency's procedure to assure access as required under part 9505.0140, subpart 2.

9505.3624 PRESCRIBED DRUGS.

Subpart 1. **Eligibility for service.** Prescribed drugs are available under CAC if the drug is prescribed by the recipient's physician, is specified in the recipient's care plan, and would be available under medical assistance to the recipient as an inpatient, as provided by *Minnesota Statutes*, section 256B.0625, subdivision 13.

Subp. 2. **Number of prescribed drugs available to recipient.** The availability of prescribed drugs under CAC is subject to the limitations under part 9505.0340. However, the number of different prescribed drugs that a recipient may fill or refill per month is not limited.

9505.3626 OTHER PROFESSIONAL SERVICES; THERAPY.

Subpart 1. **Eligibility for other professional services; therapies available as medical assistance services.** A recipient is eligible for a therapy that is available to medical assistance recipients under part 9500.1070. The therapy must be provided by a physical therapist, occupational therapist, speech-language pathologist, or respiratory therapist. The therapy provided to the recipient must comply with the provider standards set in parts 9500.1070 and 9505.3500 to 9505.3700.

Subp. 2. **Eligibility for other professional services; nutritional therapy.** Nutritional therapy is available under CAC. The therapy must be provided by a nutritionist.

Subp. 3. **Service limitations.** The amount, duration, and scope of therapy provided to a recipient by a physical therapist, occupational therapist, speech-language pathologist, respiratory therapist, or nutritionist must be ordered by the recipient's physician and specified in the recipient's care plan.

9505.3630 FOSTER CARE.

Subpart 1. **Eligibility for payment.** Foster care services to a recipient are available under CAC if the services provide ongoing residential and support services which exceed the scope of the services provided through Title IV-E or the Minnesota Supplemental Aid Program. Payment does not include room and board. For purposes of this part, "Title IV-E" means the federal program established by the Social Security Act that reimburses administrative and training costs incurred in providing services under United States Code, title 42, sections 470 to 479 and 670 to 679. "Minnesota Supplemental Aid Program" means the program established in *Minnesota Statutes*, section 256D.37.

Subp. 2. **Provider standards.** A provider of foster care services must comply with a standard specified in item A or B.

A. A provider of foster care services to a recipient under 18 years of age must be licensed according to parts 9545.0010 to 9545.0260.

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B. A provider of foster care services to a recipient who is at least 18 years of age must be licensed according to parts 9555.5105 to 9555.6265.

9505.3635 EXCLUDED SERVICES.

The following services in items A to F are not available under CAC:

A. room and board except for respite care provided outside of the recipient's residence;

B. respite care for a recipient of foster care provided under CAC if the payment agreement with the foster care provider includes the payment amount for the respite care to be purchased by the foster care provider;

C. health services for which other funding sources are available;

D. a CAC service to an individual who is not a recipient;

E. a CAC service that is not specified in the recipient's care plan as approved by the commissioner or, in the case of medical transportation under part 9505.3622, the approval of the recipient's case manager; and

F. a CAC service for a purpose other than respite care while a recipient is an inpatient as defined in part 9505.0175, subpart 17.

9505.3640 LOCAL AGENCY RESPONSIBILITIES.

Subpart 1. **Determination of applicant's eligibility for medical assistance.** A local agency must determine a CAC applicant's eligibility for medical assistance and must redetermine a recipient's eligibility for medical assistance. The determination and redetermination shall be as specified in parts 9505.0010 to 9505.0150, except that the provisions of part 9505.0075 relating to the availability of parental or spousal income and assets shall not apply. Although the local agency making the determination must be the local agency of the applicant's or recipient's county of financial responsibility, the local agency obtaining the information required under parts 9505.0010 to 9505.0150 may be the local agency in the county of service.

Subp. 2. **Designation of lead agency.** A local agency that is the county of service for a CAC applicant or recipient must designate a lead agency to administer the county's community alternative care program. The designated lead agency may be in the recipient's county of residence or service if different from the county of financial responsibility.

Subp. 3. **Calculation of parental or spousal contribution.** The local agency must determine the financial contribution to be made by a recipient's parent or spouse, as appropriate, for services to the recipient. The financial contribution of a parent or spouse shall be determined according to *Minnesota Statutes*, sections 256B.14 and 252.27, and appropriate rules adopted under those statutes. The refusal or failure of a recipient's obligated parent or spouse to pay the contribution does not affect the recipient's eligibility for medical assistance and CAC.

The local agency of the recipient's county of financial responsibility shall refer the refusal or failure to pay to the county attorney for action to enforce payment of the contribution.

9505.3645 LEAD AGENCY RESPONSIBILITIES.

Subpart 1. **Enrollment as CAC provider.** A lead agency must enroll under part 9505.0195 as a provider of CAC services.

Subp. 2. **Compliance with rules and local agency requirements.** A lead agency must comply with the requirements of parts 9505.3500 to 9505.3700 and the local agency that made the designation under part 9505.3640, subdivision 2.

Subp. 3. **Administrative functions.** A lead agency is responsible to perform the following functions in regard to CAC services to a recipient:

A. establish agreements and contracts to provide the recipient's CAC services as in part 9505.3650, subpart 2;

B. review CAC provider billings for approval for payment according to the provider's contract, purchase agreement, or service agreement with the lead agency;

C. furnish billings for CAC services according to the procedures of part 9505.0450;

D. ensure that the projected cost to medical assistance for the services specified in the recipient's care plan does not exceed the cost to medical assistance if the recipient resided in a hospital;

E. make available to the commissioner records of funds expended for CAC services; and

F. maintain and make available to the commissioner records of health services provided to recipients.

Subp. 4. **Services to recipient.** A lead agency must assure that necessary safeguards are taken to protect the health and welfare of a recipient. For this purpose, the lead agency must:

A. require CAC services to be provided as specified in parts 9505.3500 to 9505.3700, either directly or through a contract or purchase of service agreement as specified in part 9505.3650;

B. assure a CAC service, other than respite care, is not provided to a recipient while the recipient is an inpatient as defined in part 9505.0175, subpart 17; and

C. monitor providers of CAC services using the criteria in part 9505.3650.

9505.3650 PROVIDERS OF CAC SERVICES.

Subpart 1. **Criteria for selecting a CAC provider.** A provider of home and community-based services under CAC must meet the criteria in items A to C.

A. The provider must be employed by the county or have agreed as specified in subpart 2 to provide home and community-based services under CAC.

B. The provider must meet all licensure requirements and professional standards applicable to the service or services being provided as specified in parts 9505.3500 to 9505.3700.

C. The provider must not be a primary caregiver or responsible relative of the recipient to whom the provider is furnishing the home and community-based service.

Subp. 2. **Agreement to provide CAC services.** A lead agency may provide a CAC service directly or indirectly. If the lead agency chooses to provide the CAC service indirectly, the agency must have a contract, purchase agreement, or service agreement with the CAC service provider that specified the information in items A to I:

A. the beginning and ending dates of the contract or agreement;

B. the duties and responsibilities of the provider including compliance with applicable certifications, licensures, standards, and supervision of employees as required under parts 9505.3500 to 9505.3700;

C. the person or persons to be served as specified in the recipient's care plan;

D. an agreement to provide the service according to the amount, frequency, and scope specified in the care plan of the person being served;

E. the payment amount to be received for the service and the provider's agreement to accept this amount as payment in full;

F. the reports and records to be kept by the provider and given to the lead agency;

G. the provider's agreement to comply with the Minnesota Government Data Practices Act;

H. the provider's documentation of an individual abuse prevention plan that complies with parts 9555.8000 to 9555.8500; and

I. the conditions under which the lead agency shall terminate the provider's contract or agreement.

9505.3660 CAC PROVIDER RECORDS.

The lead agency and a CAC provider under contract with the lead agency must maintain for at least five years complete program and fiscal records and supporting documentation identifying the 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 provider's records are subject to the maintenance schedule, audit availability requirements, and other provisions in parts 9505.1750 to 9505.2150.

9505.3670 RATES FOR CAC SERVICES.

Subpart 1. **Maximum CAC service rate.** Unless otherwise specified by the legislature, the commissioner shall annually set the maximum rate that is available to a county as reimbursement to a provider for a CAC service. The rates for CAC services must be consistent with medical assistance rates for comparable services. Annually on July 1 after the effective date of parts 9505.3500 to 9505.3700, the commissioner shall authorize an increase in the CAC service rates available to a county as reimbursement to a CAC provider up to the percentage change forecast by the Home Health Agency Market Basket. The Home Health Agency Market Basket is published by Data Resources and is subject to quarterly revision. The Home Health Agency Market Basket is incorporated by reference and is available through the Minitex interlibrary loan system.

Subp. 2. **Notice to counties.** By June 1 of each year, the commissioner shall notify a lead agency of the statewide maximum rate allowed for payment of providing CAC services under subpart 1. Additionally, the commissioner shall notify the counties in writing of the percentage increase allowed under subpart 1.

Subp. 3. **County CAC service rate.** A county may set rates for CAC services not to exceed the rates established in subpart 1.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." **ADOPTED RULES SECTION** — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

Under no circumstances is the department responsible for payment of rates higher than those established under subpart 1 and any amounts paid in excess of those rates shall be recoverable by the commissioner. County rates are subject to audit by the commissioner.

9505.3680 DEPARTMENT RESPONSIBILITIES.

Subpart 1. **Review and approval of CAC applications.** The commissioner must review and approve or deny each request for eligibility for the community alternative care program according to the criteria of part 9505.3520. The commissioner must determine whether the applicant is eligible for home and community-based services under CAC. No later than 15 working days after receiving the information required under part 9505.3540 to determine the applicant's eligibility for CAC, the commissioner must notify the acting case manager and the lead agency of its determination or of the additional information needed to make the determination.

Subp. 2. **Review of care plan and eligibility reassessments.** The commissioner must approve or deny care plan and eligibility reassessment recommendations according to the criteria of part 9505.3520. The recipient's preexisting care plan shall remain in effect pending the commissioner's approval or denial of the reassessment recommendation.

Subp. 3. **Records.** The department must maintain records related to the community alternative care program for a period of at least five years.

Subp. 4. **Monitor program expenses.** The department must monitor CAC expenditures to assure that the expenditures do not exceed the approved waiver limits for the home and community-based services under CAC.

9505.3690 BILLING FOR CAC SERVICES.

A CAC provider must submit a claim for payment for a CAC service specified in a recipient's care plan in the manner specified by the commissioner. A claim under this part must not exceed the amount specified in the contract, purchase agreement, or service agreement between the CAC provider and the lead agency. The CAC 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.

9505.3700 APPEALS.

Subpart 1. **Appealable actions.** An applicant assessed under part 9505.3540 or a recipient reassessed under part 9505.3545 may appeal if one of the following actions is taken by the department or the local or lead agency:

A. a CAC service is denied;

B. eligibility for CAC services is not determined with reasonable promptness; or

C. a recipient's CAC services are reduced, suspended, or terminated.

Subp. 2. **Actions that are not appealable.** A denial, reduction, suspension, or termination of CAC services is not an appealable action if one of the following conditions applies:

A. the cost of the applicant's or recipient's home and community-based care exceeds the cost of hospital care;

B. the waiver aggregate average cost would be exceeded;

C. there are no openings available in the program; or

D. the case manager withdraws the CAC service or services as provided under part 9505.3560, subpart 6.

Subp. 3. **Notice of right to appeal.** An applicant assessed under part 9505.3540 or a recipient reassessed under part 9505.3545 has the right to appeal an action described in subpart 1. At the time a requested service is denied, reduced, suspended, or terminated by the case manager, lead agency, or department, the case manager must review with and provide the individual written notice about the proposed action and about the right to appeal. The notice must state the reasons for an appealable action, and an explanation of the right to appeal and how to appeal. The notice must also state that the recipient's ongoing CAC services will not be reduced, suspended, or terminated if the appeal is filed before the date specified in the notice, unless the recipient requests in writing not to receive CAC services while the appeal is pending.

Subp. 4. **Submission of appeals.** An applicant assessed under part 9505.3540 or a recipient reassessed under part 9505.3545 who wants to appeal must submit the appeal in writing to the local agency of the county of service or to the department. The appeal must be received by the department no later than 30 days after the recipient is made aware of the action taken in subpart 1 or no later than 90 days after the recipient is made aware of the action taken in subpart 1 if good cause reason for delay can be shown.

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

Subp. 6. **Continuation of services pending an appeal.** If a recipient appeals a denial, reduction, suspension, or termination of CAC services that the recipient has been receiving on an ongoing basis and that are part of the recipient's care plan approved by the recipient's physician, the lead agency must continue to provide the ongoing CAC services at the level specified in the recipient's care plan until a decision on the appeal is recommended by the department's referee and adopted by the commissioner. Nothing in parts 9505.3500 to 9505.3700 shall prohibit the department from seeking reimbursement from the recipient for the costs of providing CAC services pending a decision on an appeal if the order adopted by the commissioner is adverse to the recipient.

HOME AND COMMUNITY OPTIONS, INC.

252 WEST WABASHA STREET • WINONA, MINNESOTA 55987
(507) 452-1021

Residential Services
Office (507) 454-2343
377 Main Street
(507) 452-5909
252 West Wabasha Street
(507) 454-5377
507 Wall Street
(507) 452-8548
1165 West 5th Street
(507) 452-4370
Three Quarter Program
(507) 452-5857

Support Services
Office (507) 452-1048
Community Living Services
Respite Care
Waivered Services
58 East 5th Street
(507) 452-1048
Iverson Court
271-273 Orrin Street
(507) 454-5492

Received
Rules and Bulletins
8-27-90

August 24, 1990

Eleanor Weber
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816

Dear Ms. Weber:

I have received the bulletin announcing intent to adopt the proposed rules governing Community Alternative Care For Chronically Ill Individuals, Minnesota Rules, parts 9505.3500-9505.3700. I am writing to request a copy of the proposed rule and to request that a public hearing be held on the rule.

Please send the copy of the rule to:

Sharon Kannenberg
Executive Director
Home and Community Options
252 W. Wabasha Street
Winona, MN 55987

Sincerely,

Sharon Kannenberg

Sharon Kannenberg
Executive Director

SK/ems

Equal Opportunity Employer

COURAGE CENTER

September 10, 1990

Received
Rules and Bulletins
September 19, 1990

Ms. Eleanor Weber
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816

Dear Ms. Weber:

I am writing to request a public hearing on the Proposed Permanent Rules Relating to the Community Alternative Care Program that were published in the State Register on Monday, August 20, 1990.

3915 Golden Valley Road
Golden Valley, MN 55422
(612) 588-0811

We appreciate the excellent work that the Department has done in developing these rules and do not have any serious concerns about them. However, there are a few points on which we would like to suggest some clarification.

9505.3510, Subp. 10a. - Counseling and Training

In addition to family and individual counseling, we suggest listing group counseling (both psychotherapy and support groups) as a service that may be approved by the case manager. Group counseling services can help to fulfill the purposes described in Section 9505.3600, Subp. 3 (i.e., helping the recipient and caregivers to handle crises, develop coping strategies and reduce stress).

We suggest that the final phrase of this subpart read: "how to use medical or other adaptive equipment". Section 9505.3620, Subp. 3 allows for an exemption from the limitations on the type of equipment and supplies that can be paid for through regular Medical Assistance. This section recognizes that there are many different adaptive devices that can ease the burden on caregivers and help recipients to function more independently so that institutionalization can be avoided. Even if adaptive equipment is not "medically necessary" in the strict sense of the term, it can often lower costs by reducing the need for hands-on care by trained staff. This broader interpretation is what distinguishes the equipment provisions in the Waiver from those under regular Medical Assistance.

9505.3510, Subp. 31 - Medical Social Worker

We suggest the wording: "'Medical Social Worker' means an Independent Clinical Social Worker (LICSW), licensed under MN Statutes 148B.18 to 148B.28, who has had social work experience in a hospital, outpatient clinic, medical rehabilitation, or medical care program."

Courage Center is a nonprofit organization providing rehabilitation and independent living services for children and adults with physical disabilities and sensory impairments.

Equal Opportunity Provider

9505.3510, Subp. 37 - Physical Therapist

We suggest the following wording: "'Physical therapist' means a person licensed by the State of Minnesota or eligible to be licensed as a physical therapist." Registration with the American Physical Therapy Association is voluntary, whereas State licensure is mandatory. The phrase "eligible to be licensed" would cover therapists who have been licensed in another state and who are simply waiting for the paperwork to be processed in order to obtain their Minnesota licensure.

9505.3510, Subp. 49 - Social Worker

We suggest re-labeling this subpart as "County Social Worker" to further distinguish the duties of county social workers from those of social workers who may be involved in providing counseling services.

We appreciate this opportunity to comment. Please don't hesitate to contact me if you or other Department staff have any questions.

Sincerely,

Anita Boucher
Program Development Specialist
520-0533

STATE OF MINNESOTA
Board of Social Work

2700 University Avenue West • Suite 225 • St. Paul, Minnesota 55114 • (612)643-2580

September 17, 1990

Eleanor Weber
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816

Dear Ms. Weber:

The Minnesota Board of Social Work has prepared the following comments regarding **Proposed Permanent Rules Relating to Community Alternative Care Program.** The Board is concerned that the definitions related to Social Workers provided in this proposed permanent rule may need clarification.

Please consider these comments as a request for clarification by the Board regarding the proposed definitions as presented in the State Register on August 20, 1990.

MN Rule Part 9505.3510

Subp. 7. Case Manager:

Currently Social Work Case Managers employed by a County (the lead agency) are not required to be licensed and are therefore exempt from licensure requirements as set forth in Minnesota Statutes, sections 148B.21-148B.23. However, Social Work Case Managers employed by another agency are be required to be licensed by the Board of Social Work.

Subp. 31. Medical Social Worker:

Currently Social Workers employed by a hospital facility are not required to be licensed by the Board of Social Work. However, other situations indicated in this section may require licensure by the Board of Social Work.

(continued)

Celebrate MINNESOTA 1990

Subp. 49. Social Worker:

Currently Social Workers employed by a County or the State are not required to be licensed. However, as noted above, other non-county and non-state employees are required to be licensed within the scope of Minnesota Statutes, sections 148B.21-148B.23.

I have attached a copy of the statutes that govern the Board of Social Work. The language regarding exemptions for licensure can be found in section 148B.28.

Please feel free to contact me directly regarding these clarifications.

Sincerely,

Patricia J. Puetz
Executive Director

reaching for independent living ©mota

Minnesota Occupational Therapy Association

2810 Aquila Ave. So. • P.O. Box 26532 • Minneapolis, Minnesota 55426 • (612) 938-3123

September 19, 1990

Eleanor Weber
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816

Dear Ms. Weber,

I am writing in response to the proposed rules for Community Alternative Care Program. My comments are merely technical and therefore not controversial.

Occupational Therapists are not long registered nationally with the American Occupational Therapy Association. We are, and have been for the last several years, registered by the American Occupational Therapy Certification Board. This should be corrected in 9505.3510, Subp. 36.

As this change was made nationally, we have been discovering the need to change the definition of O.T. every time a rule comes up for revision or a new rule is proposed. Is there any way to find out how many other rules need to have that change and take care of them all at once?

Thank you for your consideration.

Sincerely,

Karen Sames

Karen Sames, MBA, OTR
MOTA President

HENNEPIN
COMMUNITY HEALTH DEPARTMENT
Pre-Admission Screening Program
Health Services Building - Level 3
525 Portland Avenue South
Minneapolis, Minnesota 55415

September 27, 1990

Ms. Eleanor Weber
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155

Dear Ms. Weber:

I have put in writing the comments that I gave Phyllis over the phone on Monday (9/24/90) on the proposed rules for the Community Alternative Care Program parts 9505.3500 to 9505.3700 that is dated 8/1/90.

I want to add that I continue to be impressed with the fine work of DHS staff in developing this rule. I was on the public advisory committee that originally worked on this rule, and DHS staff have done a very good job of seeking comments from those of us in Hennepin County who will have to live with the CAC rule.

I do have a few comments, which are listed below:

Designation of the Primary Caregiver, part 9505.3520, item "D", p. 9, lines 25-26: in order for a CAC care plan to work, the case manager must determine that the primary caregiver is capable; so I am requesting that the phrase "by a health care professional" be changed to "the county case manager." That case manager will obviously consult with other such as the nurses providing home care, but final responsibility must rest with the case manager.

State Forms: there are several requirements for counties in the draft rule that are met by using mandated DHS forms (i.e., subp 6, pp 13-14 on "Rights, Appeals, and Freedom to Choose," "contents of the care plan" subp 8, pp 14-15, "Notice of Action #1," p. 19 lines 24-29). I request that the rule clearly state that the counties must use the forms as designated by the commissioner as you have done in the "Authorization to release information" subp 5 p. 13, lines 18-19.

Respite Care in the recipient's home #B, p. 22, lines 2-6: I am requesting that when a nurse provides respite care in the recipient's home, and particularly when the recipient is a child, the primary caregiver must designate a person who can make decisions about the recipient's home (e.g., if the furnace fails, or the plumbing springs a leak). The nurse needs to have a person who can be asked to make decisions about getting immediate repairs.

Medical Equipment #C, p. 24, line 24: I am requesting that the figure of $25 be deleted and the following language be substituted: "they exceed the value per month that is allowed by the waiver;" thus, if and when Phyllis gets the waiver amended for this number, you will not have to amend their rule.

Contracts and agreements: thanks for giving us the flexibility to have both of these. As an editorial note, it would have been clearer if you would have cited this requirement in the parts of the rule that refer to counseling/training, medical equipment, and foster care.

Calculation of parental or spousal contribution, subp 3, p. 27. lines 30-35, and p. 28, lines 1-8: DHS is handling the computation and collection of contributions from parents of MA children living out of the home or on Tefra--I assume the amount would follow that scale. It would be most effective/least confusing if DHS handled all contributions, including these, and not require county attorneys to get involved.

As always, I appreciate your good work. If you have questions or comments, please call me at 348-4464.

Sincerely,

Todd Monson
CAC Program Manager

TM:db

Minnesota Nurses Association
1295 BANDANA BLVD. NO., SUITE 140
ST. PAUL, MINNESOTA 55108-5115
(612) 646-4807

received
Rules and Bulletins
Division
8-20-90

August 16, 1990

Eleanor Weber
Rules Division
DHS
444 Lafayette Road
St. Paul, MN 55155-3816

Dear Eleanor,

Thank you for the opportunity to comment on the proposed rules relating to the Community Alternative Care Program (CAC) Rule 70.

Minnesota Nurses Association has a few comments with regard to this rule which are mainly technical in nature. Briefly, our comments are as follows:

9505.3510 DEFINITIONS

subpart 39 Prescribed Drug

The definition states that a prescribed drug must be ordered by a "recipients physician." In the 1990 legislative session Certified Nurse Practitioners were given the authority to write prescriptions as delegated by a physician. Certified Nurse Midwives have had prescription writing authority for several years. Because Nurse Practitioners and CNMs are often primary care providers in rural and underserved areas and are widely employed in physician clinics throughout the state, we believe that this rule should recognize that a prescribed drug may be ordered by a Nurse Practitioner or a Certified Nurse Midwife. Also, it is important to note that Physician Assistants also have prescribing authority under Minnesota law. MNA, therefore would suggest the following definition for prescribed drug.

"Prescribed drug" means a drug defined in Minnesota statutes, section 151.01, subdivision 5, ordered by a health care provider with legal authority to write prescriptions in Minnesota and specified in the recipients care plan.

Subpart 42 Public Health Nurse

The agency with authority to certify public health nurses is the Minnesota Board of Nursing rather than the Minnesota Department of Health.

Subpart 34 Nursing Services

This definition reads as to imply that nursing services can only be provided if ordered by a physician. The Minnesota Nurse Practice Act outlines a number of independent nursing functions which do not require physician orders but may be initiated by an Registered Nurse.

The definition of nursing services should be revised in order to recognize that the RN practices under the entire scope of nursing practice as defined under the Nurse Practice Act, and the Licensed Practical Nurse functions under a very limited scope which does not include supervision of paraprofessionals. Therefore, it might make more sense to list the Registered Nurse first. The definition should be revised to read:

"Nursing Services" means services specified in the recipient's care plan, and provided by or under the supervision of a Registered Nurse or by a Licensed Practical Nurse".

9505.3624 PRESCRIBED DRUGS

Subpart 1 Eligibility for Service.

This subpart is inconsistent with current Minnesota Law by stating that prescribed drugs must be prescribed by a physician (see comments under 9505.3510 subpart 39). The first sentence of that subpart should be revised to include all Health Care Professionals with authority to write prescriptions under Minnesota Law.

9505.3510

Subpart 17 Because the definition proposed for a health care professional includes Licensed Practical Nurses and the term "Professional Nurse" refers only to an RN under the Nurse Practice Act, MNA would suggest the following:

> The list of individuals under this definition could be more accurately described as "Health Care Providers" when the Licensed Practical Nurse is to be included in the list.

Or another approach could be to drop the Licensed Practical Nurse from the definition of Health Care Professionals altogether. The services of the Licensed Practical Nurse would continue to be provided and the Licensed Practical Nurse could still be included as part of the interdisciplinary team under item "I" of 9505.3535.

Thank you again for the opportunity to comment on these rules. Please feel free to contact me if you have any questions about MNA's comments on this rule.

Sincerely,

Susan Stout, RN
Staff Specialist, Governmental Affairs

SS:caa



April 23, 1986

Cathrine Griffin, C.A.C. Coordinator
Long Term Care Management
Department of Human Services
444 Lafayette Road
St. Paul, MN 55101

Minneapolis
Children's
Medical Center

Dear Cathrine,

We want to thank you for the opportunity to participate in the rule making process for the Community Alternatives for Children Program. We support the proposed rules the task force developed and that you have mailed to us for review. We recognize that rule making is a time consuming and difficult process and we appreciate your efforts to involve a network of community providers. If you are in need of further information or comments feel free to call on anyone of us at any time.

A physician, Joann Gates, from the New Orleans Ventilator Program, may be calling you in the next several weeks regarding implementation of our waiver program and maintaining a variety of children at home on ventilators. She is interested in the work that we have done with legislative activity and a variety of community providers in maintaining children at home at a cost effective manner. We shared your name with her at a recent national conference and felt that you would be a wonderful source of information regarding issues and planning at the state level.

Once again, thank for your efforts in the rule making process and we look forward to working with you again in the future.

Sincerely,

Barbara Balik

Barbara Balik,
Clinical Director of Nursing

Becky Bedore

Becky Bedore,
Minneapolis Children's
Home Care Program

RULE Rule 70 (NUMBER) · DRAFT OF 2:062090 (DATE)

COMMENT SHEET OF Todd Mouso (NAME OF REVIEWER)

RETURN TO:
ELEANOR WEBER
RULES DIVISION
DHS
444 LAFAYETTE ROAD
ST. PAUL, MN 55155-3816

USE BLACK INK

IDENTIFY EACH COMMENT BY PAGE, RULE NUMBER, AND SECTION NUMBER, AND YOUR INITIALS

PAGE	RULE	SE.	COMMENT	IN
3	Subp 10		is the CAC Program still specified in a "model" waiver — I thought the word model no longer applied	
3	Subp 10a		in the last line we teach families how to perform a treatment regimen — not how to "use" a regime	
8	Subp 39		I believe that Minnesota State law was changed this session (1990) to allow nurse practitioners to prescribe some medications if the practitioners are registered with the State (Mn Chapter 483)	
11	Subp F		does "inpatient hospital services" include physician, therapy costs etc?	
13	Subp 1		Aren't there problems with the Minnesota Data Privacy Act in terms of notifying everyone designated herein without a written release from someone beforehand?	
[also p 15 subp 5]				
14.	Subp 2		Must all of the people designated be notified of the reassessment — by the time of the reassessment — the schools, the Services for Children with Handicaps are involved or they aren't — depending on the child's status, I request that the specific people who must attend or be notified of a reassessment be left to the discretion of the county case manager — we need some efficiencies here	
[also page 19, subp 1]				

AGE	RULE	SEC.	COMMENT	INIT
17	Subp A-D		I would like some mention of the need for an emergency backup plan that is in writing	
18	Subp 9		Why not just require the team to submit whatever documents the Commissioner requires rather than looking us into these specific documents & then if there are changes in the types of documents the Rule would have to be amended	
19	Termination =		should you state that loss of MA eligibility is a reason for termination or that in some cases CAC services are not cost effective e.g. when an HMO covers some but not all services	
20	Subp 2		the lead agency has five "working" days to designate a case manager	
23	Subp 3		for this section the homemaker contract must meet Mn statutes 144A.43–144A.46, but on P. 56 of this rules homemaker is define in 9565.1100 and 9565.1200	
24	Subp A		out-of-home respite at Camp Courage which Phyllis has approved is not at a "state licensed facility" — there are no state licenses for Camp Courage which is certified by the state Health Department does it meet the food preparation	
25	9505.3600		I prefer the CAD: Rule's language for counseling and training – it is more specific	
26	9505.3610		it would be far easier for counties to establish "agreements" rather than "contracts" – home mods are often one shot deals & carpenters don't want to sign a 20 page county contract to build a $1,000 ramp { see P 32 subp 2 which refers to a contract, purchase agreement or service agreement	

.27 subp 2 (prior approval): most equipment and supplies cost more than $25, so I request a higher ceiling ~~i.e.~~ before prior approval is required, the ACG and CAD: programs are moving to a $150 cutoff, it would be helpful if CAC/CAD:/ACG had the same limits

.5 subp 5 (sorry I'm out of order) the draft rule requires a separate form to be signed for each authorization of release of information, but the Hennepin County Attorney's office had approved a broader release for us — see the attached copy — I think Sue Larsen at OHS might support our type of form

COMMUNITY HEALTH DEPARTMENT
Pre-Admission Screening Program
Health Services Building – Level 3
525 Portland Avenue South
Minneapolis, Minnesota 55415

AUTHORIZATION TO RELEASE INFORMATION

I give permission for Hennepin County Pre-Admission Screening to release any and all records and information to:

1) other Hennepin County Departments/Bureaus and/or
2) the attached list of vendors and/or
3) appropriate family members or person who may be acting as my guardian or representative and/or
4) other contacts _____

_____

_____

This information will be used to determine the appropriateness of one or more of the following: nursing home admission; continued nursing home placement; provision of community services; establishment of a plan of care in his/her home; for

_____.
(client's name)

I also give permission for aforementioned to release any information they may have to Hennepin County Pre-Admission Screening.

Signature: _____

or Representative Signature: _____

Date: _____ Expiration Date: _____
(one year)

Other Hennepin County Departments/Bureaus that have access to this information:
1) Hennepin County Medical Center
2) Office of Planning and Development
3) Bureau of Social Services
4) Department of Information Services

7/89

7/3/90 (faxed)

To: Todd Monson, Hennepin County Pre-Admission Screening

From: Anita Boucher, Courage Center

Re: Licensure/certification of Courage Camps

Attached is the cover page from the American Camping Association (ACA) standards manual that I promised to send you. As I mentioned we have a 3-year accreditation under the ACA standards for Camps for Special Populations.

As a child of the sixties, I was somewhat alarmed by Part II-G's "Tripping Standards", but I suspect they're referring to camp-out's in the woods--not to what [redacted] thinking of...

The Minnesota Department of Health surveys us once a year for our "Permit for Operation of a Children's Camp". As I mentioned, there is no permit for adult camps.

Our food service is also reviewed annually by the U.S. Department of Agriculture because we receive some funding through the Summer Food Program.

Courage Center is also accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). We are currently reviewing some draft standards on respite care that CARF has just issued and may consider having our camp respite programs accredited by CARF.

Let me know if you need any additional information.

cc: Bob Polland, Camping
Mark Moilanen, Associate Executive Director

EW: I was wrong about one of my comments on the CHC Rule & Respite Care = Camp Courage is licensed or at least has a permit for kids

— 11 m

SAINT LOUIS COUNTY
SOCIAL SERVICE DEPARTMENT

Robert J. Zeleznikar
Director

☐ ADMINISTRATIVE OFFICES
Government Services Center
320 West Second Street
Duluth, MN 55802
(218) 726-2000

May 23, 1988



Ms. Phyllis Zwieg
Community Care Coordinator
Long Term Care Management Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3844

Dear Ms. Zwieg:

I have reviewed with interest the "Draft" Community Alternative Care Program (CAC) Rule and have a number of questions and concerns. While I will be unable to attend the May 25th public advisory committee meeting, I would like to have my comments shared at this meeting.

1. Local Agency/Lead Agency Responsibility
   Page 12 of the Rule indicates that the "local" agency must designate a "lead" agency to administer the CAC program. Further, on page 10, providers of CAC services must be employed by or contract with the "lead" agency. If it is the Program's intent that the "lead" agency fill this administrative role, why then is the "local" agency charged with the responsibilities regarding notification and convening of the annual public meetings (p.11)?

2. Contracting for CAC Services
   Who contracts with the CAC Providers? Page 10 (9505.3580 - Subpart 1A) indicates that the provider must be employed by or contract with the "lead" agency yet on page 11 (subpart 2) the contract specifications are identified for the "local" agency.

3. CAC Provider Selection
   A general concern regarding the structure of the rule relative to selecting CAC providers is that there appears to be the potential for having a greater number of contracted providers than there are CAC eligible clients to serve. A similar situation exists relative to the requirement that ACG respite care be provided by a contracted nursing home or boarding care home. St. Louis County has Agreements with 8 facilities yet has only used ACG-Respite Care on 13 occasions in 1988.

   An alternative for CAC might be permit the administering agency to contract on a case specific basis as the need develops utilizing selection criteria identified on page 11 (Subpart 5).

☒ Reply to

☐ Northland Office Center
307 South First Street
Virginia, MN 55792
(218) 749-7100

☐ Graysher Shopping Center
Hibbing, MN 55746
(218) 262-6000

☐ 118 South Fourth Avenue East
Ely, MN 55731
(218) 365-6151

AN EQUAL OPPORTUNITY EMPLOYER

Such formalizing of the plan of care into the CAC Agreement would simplify contracting for the administering agency while assuring the provision of quality care for CAC clients.

I would like to attend future meetings of the public advisory committee and would appreicate receiving minutes and meeting notices.

Sincerely,

Stan Kaitfors

Stan Kaitfors
Planning & Contract Services

SK/pjm

cc: Catherine Griffin
Ellen Kronschnabel
Gordon Fon
Douglas Britton
Jay Anderson
Bill Paulsen

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
Human Services Building
444 Lafayette Road
St. Paul, Minnesota 55155-38___

July 5, 1988

Stan Kaitfors
St. Louis County Social Services
Department
Government Services Center
320 W. Second Street
Duluth, Minnesota 55802

Dear Mr. Kaitfors:

This letter is in response to your May 23 correspondence regarding the draft administrative rule for the Community Alternative Care (CAC) Program.

Thank you for your comments and recommendations for amendments and clarification to the draft rule. I read your comments to the public advisory committee members that were in attendance at the May 25 meeting.

Attached is a revised draft of the CAC Program administrative rule. We have incorporated your recommendations and those from the May 25 meeting. A draft of the provider standards were handed out at the meeting. The standards have now been incorporated in the draft.

We have deleted the proposed section on public meeting notices for CAC Program providers. As you will see on page 19 of the revised draft, standards for providers of CAC services only, are addressed. The intent is that an administering agency should contract on a case specific basis.

On page 18 of the revised draft we have attempted to clarify "lead" and "local" agencies responsibilities. If you see discrepancies in these areas, please let me know.

We appreciate and value the input that you have given us.

A date for the second public advisory committee meeting has been set. The meeting will begin at 1:00 PM on Thursday, July 28. The meeting will be held on second floor, rooms 2A and 2B in the Human Services Building, 444 Lafayette Road, St. Paul. (Map attached.)

AN EQUAL OPPORTUNITY EMPLOYER

Please feel free to contact me if you have concerns regarding our draft of the administrative rule. We look forward to seeing you on July 28.

Sincerely,

Phyllis Zwieg

Phyllis Zwieg
Community Alternative Care Program
Long Term Care Management Division

Attachments

PZ:cb

cc: Catherine Griffin
Ellen Kronschnabel
Gordon Fon
Douglas Britton
Jay Anderson
Bill Paulsen

Children's Hospital

345 N. Smith Avenue
St. Paul, MN 55102
(612) 298-8720

Department of Child and Family Services



July 11, 1988

Phyllis Zwieg
Dept. Of Human Services
Long Term Care/Community Alternatives
444 Lafayette Road, 3rd. Floor
St. Paul, MN 55105

Dear Phyllis:

Since I will not be able to attend the July 28th. meeting to further review the Community Alternative Care Program Administrative Rule, I am sending you my comments.

My first comment concerns the need for further clarification between the rules of acting case manager and the ongoing case manager. During my recent experience working with Anoka County Public Health on a CAC application, there was disagreement on the responsibilities of the acting versus the ongoing case manager. According to p. 12 Subp. 2 Responsibilities, the case manager is responsible for completing and submitting the CAC application. However, in the case of a hospitalized patient, the ongoing case manager might not be named until the CAC application has been submitted and approved. I think that further clarification would be very helpful.

One other concern is on p. 18, 9505.3646 Local Agency Duties. According to the definition of Local Agency, it is the agency which administers Medical Assistance. In larger counties such as Ramsey, the Medical Assistance staff and the unit in which intake for Social Work Services occurs work quite independently of each other, and public health nursing is a totally seperate agency. My point is that this may not be an effective mechanism for designating a social worker and a public health nurse. Additionally, in Ramsey County Community Human Services, there is some resistance to assigning a social worker in this type of a situation. If the CAC rule is requiring that a social worker must be assigned from the county social work agency, will this be communicated to all of the county social work agencies?

I'm impressed with all the work that you've done on this CAC Rule. This is my first exposure to this process and I had no idea how involved it was.

Sincerely,

Sue Lamoureux

Sue Lamoureux, ACSW
298-8720

SL/sc

In the Matter of the Adoption
of the Rule of the State Department
of Human Services Governing Community
Alternative Care Program, Minnesota
Rules, Parts 9505.3500 to 9505.3700

DECLARATION OF
COUNSEL

I, Kim Buechel Mesun, Special Assistant Attorney General, do hereby declare that I have examined the above-captioned rule, and the supporting rulemaking record, and that, based on my examination, the Administrative Procedure Act and Minnesota Rules, chapter 2010 have been followed. Any exceptions are listed below. For Attorney General billing purposes, the four-digit docket client code is 0866 .

Kim Buechel Mesun

Special Assistant
Attorney General

Dated: November 29 , 1990

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of the Rule of the State Department of Human Services Governing the Community Alternative Program, Minnesota Rules, Parts 9505.3500 to 9505.3700	NOTICE OF SUBMISSION OF RULE ADOPTED WITHOUT PUBLIC HEARING TO THE ATTORNEY GENERAL

Pursuant to your request and in accordance with Minnesota Statutes, section 14.26:

PLEASE TAKE NOTICE that the above-captioned rule has been submitted to the Office of the Attorney General on the date of this notice, November , 1990 for review as to legality and form to the extent the form relates to legality. The proposed rule, the rule as adopted, all the notices, the Statement of Need and Reasonableness, all written comments and requests for a hearing received, and other required documents also have been submitted to the Attorney General.

The proposed rule which was published in the State Register and made available to the public on August 20, 1990, has been modified. A free copy of the rule as modified as well as the findings of fact, conclusions, and order explaining the amendments and adopting the rule is available upon request from:

Eleanor Weber
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155
(612) 297-4301

The rule must be approved or disapproved by the Attorney General within 14 calendar days of the date of the submission to the attorney general. You may submit written comments to the attorney general on the legality of the rule. Any written comments must be submitted within eight calendar days of the date of submission of the rule to the Attorney General. Your comments must address only the issue of legality of the rule or the legality of the specific parts or subparts of the rule. The attorney general standards for review are set forth in Minnesota Rules, part 2010.1000. You may receive a copy of the attorney general decision upon written request to the attorney general. Your comments or requests for the decision must be directed to:

The Office of the Attorney General
204 Administration Building
50 Sherburne Avenue
St. Paul, MN 55155
Telephone Number: (612) 296-1288

Any written comments submitted to the Attorney General must be submitted simultaneously to:

Eleanor Weber
Rules and Bulletins Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816
(612) 297-4301

Date: November 29, 1990

Eleanor Weber

Eleanor Weber
Assistant Director
Rules and Bulletins Division

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ADMINISTRATIVE
HEARINGS

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

In the Matter of Proposed Rules of the Department of Human Services Governing Community Alternative Care for Chronically Ill Individuals Who Are Eligible for Medical Assistance and at Risk of Hospitalization, Minnesota Rules, Parts 9505.3500 to 9505.3700

STATEMENT OF NEED AND REASONABLENESS

Introduction

The proposed rules, parts 9505.3500 to 9505.3700 govern the community alternative care (CAC) program for chronically ill individuals who are hospitalized or who require frequent hospitalization. The authority for this rule is derived from Minnesota Statutes, section 256B.49, subdivision 2.

Parts 9505.3500 to 9505.3700 enable the Department of Human Services to establish a framework for counties to: 1) instruct interdisciplinary teams and case managers how to process an application for home and community-based services for chronically ill individuals eligible to receive medical assistance as hospital inpatients; 2) develop care plans to enable eligible individuals to remain in the community; 3) select providers of home and community-based services; 4) set standards for home and community-based service providers; 5) authorize reimbursement for services; and, 6) bill the Department for reimbursement of services.

History of the Community Alternative Care Program (CAC)

CAC is a home and community-based services program authorized for medical assistance recipients under a waiver from the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services. The waiver which has been in effect in Minnesota since 1985 permits the state to provide health services specified in the State Medicaid Plan without regard to the "amount, duration, and scope of the services" specified in the Plan. Additionally, the waiver permits the state to extend the home and community-based services under CAC to persons who would otherwise be ineligible for medical assistance provided under Title XIX of the Social Security Act, 42 U.S.C. 1392a, et seq., while living at home because of the Supplemental Security Income (SSI) deeming rules but who would be eligible for medical assistance if they were institutionalized. See Attachment A, State Medicaid Manual, section 4440 B. Initially, only chronically ill children were served under CAC, but the 1987 amendment to the waiver extended eligibility to any individual under age 65 at risk of hospitalization.

Minnesota Statutes, section 256B.49, authorizes the Department of Human Services to apply for the waiver. The statute states that the waivers are requested "to furnish necessary services in the home and community setting to childen or disabled adults under age 65 who are medicaid eligible when

institutionalized in an acute care or nursing home setting." Under the statute, the "commissioner shall assure that the medical assistance cost of home and community-based care will not be more than the medical assistance cost of care if the eligible child or disabled adult under age 65 were to remain institutionalized."

The purpose of the program is to save medical assistance program costs by making health care services outside of a hospital available to the target population, chronically ill individuals under 65 years of age. (See Attachment A.,Sec. 4440, State Medicaid Manual, Part 4, Services.) Some savings have been substantial. For example, in September of 1989, the average medical assistance cost of CAC services for the 39 persons on the program was 53 percent of comparable hospitalization costs paid by medical assistance.

The waiver approved by HCFA for Minnesota specifies the home and community-based services that are available, in addition to medically necessary medical assistance services, to individuals under age 65 who reside in a hospital or are at risk of hospitalization. These services include case management services, which the waiver, and these rules, require for CAC recipients. The waiver also contains the specific service standards and eligibility criteria which must be met as a condition of receiving federal financial participation in the costs of the home and community-based services. A copy of the waiver is in Attachment A.

CAC is a cooperative effort between the Department of Human Services and county agencies. The department has the obligation of assuring HCFA that, in implementing the program, the state has met all the requirements and limits specified in the waiver. The Department is also responsible for determining eligibility to participate in the program, approving care plan funding, and complying with the conditions specified in the waiver. For their part, the counties have the responsibility of implementing the program. Counties are responsible for organizing interdisciplinary teams, conducting assessments, developing home care plans, case management, contracting for or directly providing services, reporting CAC-related activities to the commissioner, and submitting service invoices.

At present, only 17 Minnesota counties are providing services to CAC recipients. These counties are listed in Attachment B.

<u>Rule Development Procedure</u>

Proposed parts 9505.3500 to 9505.3700 have been developed according to the requirements of Minnesota Statutes, Chapter 14, The Administrative

Procedure Act. The department established a public advisory committee whose membership included persons representing county agencies, service providers, client advocates, and other state agencies concerned with health care issues. The committee provided guidance to the department about the proposed rules through a process of review and comment of early rules drafts prepared by the department. The department considered the committee's guidance in completing the proposed rules as published.

The committee met on May 25, 1988 and July 28, 1988. Committee membership is in attachment C.

Small Business Requirements

In preparing these rules, the Department considered the requirements of Minnesota Statutes, section 14.115 in regard to small businesses but believed that these rules come within the exemption given in section 14.115, subdivision 7 (c) because either the providers affected by this rule are providers of medical care or compliance with the waiver specified provider standards is required under Minnesota Statutes, section 256B.04, subdivision 4. Minnesota Statutes, section 146.01 states:
The term "practicing healing" or "practice of healing" shall mean and include any person who shall in any manner for any fee, gift, compensation, or reward, or in expectation thereof, engage in, or hold out to the public as being engaged in, the practice of medicine or surgery, the practice of osteopathy, the practice of chiropractic, the practice of any legalized method of healing, or the diagnosis, analysis, treatment, correction, or cure of any disease, injury, defect, deformity, infirmity, ailment, or affliction of human beings, or any condition, or conditions incident to pregnancy or childbirth, or examination into the fact, condition, or cause of human health or disease, or who shall, for any fee, gift, compensation, or reward, or in expectation thereof, suggest, recommend, or prescribe any medicine or any form of treatment, correction, or cure thereof; also any person, or persons, individually or collectively, who maintains an office for the reception, examination, diagnosis, or treatment of any person for any disease, injury, defect, deformity, or infirmity of body or mind, or who attached the title of doctor, physician, surgeon, specialist, M.D., M.B., D.O., D.C., or any other word, abbreviation, or title to the person's name indicating, or designed to indicate, that the person is engaged in the practice of healing.

Thus a person "practicing healing" as defined above is considered to be involved in the practice of a health service that constitutes medical care.

Certain services covered under these rules are furnished by or under the supervision of providers of medical care or practicing healing as defined above. Such CAC services include home health services, part 9505.3570;

home health aide services, part 9505.3590; medical equipment, part 9505.3620; prescribed drugs, part 9505.3624; and other professional services, part 9505.3626.
Other services covered under these rules cannot be categorized as health care or medical care but are health care related and are included in the waiver because they enable the recipient to live in the community. The waiver authorizes the use of medical assistance funds to pay the cost of these services for eligible persons and specifies the services limits and the criteria to be service providers. The waiver authorization to pay for these services under medical assistance has led to increased business for agencies providing these community-based services as a result of the larger population which needs the services within the community. These services include homemaker services, part 9505.3575; respite care services, part 9505.3580; family counseling and training services, part 9505.3600; environmental modifications in the home, part 9505.3610; medical transportation, part 9505.3622; foster care, part 9505.3630; and

case management services, part 9505.3570. The cited rule parts reflect the criteria established in the waiver. Furthermore, it should be noted that the waiver requires the standards to be the same for all providers of the same service. Compliance with waiver requirements ensures that these CAC services will qualify for federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4.

It also should be noted that CAC service providers must have a contract, purchase agreement, or service agreement with the lead agency (part 9505.3645) and that the lead agency which is required to publicize the opportunity to be a CAC service provider has been approved by the county board to administer the county's CAC program.

These rules will not affect the present reimbursement of inpatient hospitals as hospitals receive medical assistance payment for acute care services that may become necessary for CAC recipients. Such payment will be based on the recipient's diagnosis at the time of admission and in accordance with parts 9500.1090 to 9500.1155. It should be noted that hospitals may provide respite care to CAC recipients as a contracted service under CAC.

In the event that these rules are not exempt under subdivision 7, the department has considered the methods listed in subdivision 2 of section 14.115 for reducing the impact of the rule on small businesses. In considering these methods, the department was mindful of the need to comply with extensive federal and state requirements applicable to the medical assistance program. Medical assistance is a federal program established under Title XIX of the Social Security Act, 42 U.S.C 1396a, et seq. Title XIX and its implementing regulations specify the program standards and limitations and reporting requirements with which a state must comply to obtain federal financial participation in paying the cost of the program. Minnesota Statutes, section 256B.04, subdivision 4 requires the department to cooperate with the federal government "in any

reasonable manner as may be necessary to qualify for federal aid in connection with the medical assistance program, including the making of such reports in such form and containing such information as the department of health, education, and welfare may, from time to time, require, and comply with such provisions as such department may, from time to time, find necessary to assure the correctness and verifications of such reports." Minnesota Statutes, section 256B.04, subdivision 2 requires the department to "make uniform rules, not inconsistent with law,....to the end that the medical assistance system may be uniformly administered throughout the state...." 42 CFR 431.50 (b)(1) requires a state medical assistance plan to provide that "the plan will be in operation statewide...under equitable standards for...administration that are mandatory throughout the State." Similarly, 42 CFR 433.33 requires the state medical assistance plan to assure that "individuals in similar circumstances will be equitably treated throughout the State." Thus, in addressing the concerns of Minnesota Statutes, section 14.115, subdivision 2, it is necessary and reasonable to review the requirements of federal law and regulations about program standards and reporting requirements.

Clause (a) of subdivision 2 requires consideration "of the establishment of less stringent compliance or reporting requirements for small businesses." 42 U.S.C. 1396 (a)(10)(B) requires the amount, duration, and scope of medical assistance to be the same for all persons receiving services under (10)(A). 42 U.S.C. 1396 (a)(19) requires medical assistance to provide services "in a manner consistent with simplicity of administration and the best interests of the recipients."

Clause (b) requires consideration of the "establishment of less stringent schedules or deadlines for compliance or reporting requirements for small business."

Clause (c) requires consideration of "the consolidation or simplification of compliance or reporting requirements for small businesses." Because of their similarity the provisions of these clauses were considered together.

42 U.S.C. 1396 (a)(27) requires every person or institution providing medical assistance services to "keep such records as are necessary to fully disclose the extent of the services provided to" recipients and to furnish the state or the federal government any information required about payments for services. These reporting requirements are minimum standards applicable to all providers of the same services and are not based on how much medical assistance business the provider does. Thus, it is necessary and reasonable to set uniform administrative standards for the medical assistance program and reporting requirements.

Clause (d) requires consideration of "the establishment of performance standards for small businesses to replace design or operational standards required in the rule." 42 U.S.C. 1396 (a)(30) requires the state to assure that medical assistance payments are consistent with quality of care and to provide methods and procedures related to utilization review of the service toward this end. This requirement ties the medical assistance program to stringent compliance in regard to quality of care and does not permit the state to establish different levels of quality of care according to the size of the provider's business. Additionally the licensure standards with which the providers must comply to obtain and

retain their licenses set uniform standards applicable to all license holders without regard to the size of the license holder's business.
Clause (e) requires consideration of "the exemption of small businesses from any or all requirements of the rule."
42 U.S.C. 1396 (a)(10)(B) requires the amount, duration, and scope of medical assistance to be the same for all persons receiving services under (10)A. Minnesota Statutes, section 256B.04, subdivision 2 requires the department to "make uniform rules...to the end that the medical assistance system may be uniformly administered throughout the state,..." The program and reporting standards in these rules have been accepted by the advisory committee as consistent with the prevailing standard among providers and representatives of users of home and community-based services. No members of the advisory committee suggested having more than a single set of program and reporting standards.

Thus, the Department believes it would be unreasonable and contrary to federal and state laws and regulations to modify the proposed rule to establish less stringent compliance or reporting standards, deadlines, simplified requirements, or exemptions in response to clauses (a) to (c) and (e) of Minnesota Statutes, section 14.115, subdivision 2. The Department also believes that the proposed rules do not contain design or operational standards as referenced in clause (d) of Minnesota Statutes, section 14.115, subdivision 2.

It should be noted that the Department in its Notice of Intent to Adopt a Rule Without a Public Hearing the Department has invited anyone who may be affected as a small business to address their concerns in writing to the Department. Such letters will be part of the official public rule record submitted to the Attorney General for consideration.

9505.3500APPLICABILITY AND EFFECT

Part 9505.3500 sets forth the applicability and effect of the proposed rules.
Subpart 1. **Applicability.** This subpart lists the federal and state laws and federal regulations which authorize the department to adopt these rules and which state the requirements for the content of these rules. This part also states that these rules must be read in conjunction with Minnesota Statutes, section 256B.49, Minnesota Rules, Ch. 9505, and the waiver. This part is necessary and reasonable to inform persons affected by the program of the basis of these rules and other rules that affect CAC recipients and providers.
Subp. 2. **Effect.** The waiver is approved by the United States Department of Health and Human Services, Health Care Financing Administration (HCFA). The present waiver which became effective April 1, 1988, is a five year extension of the initial waiver which was approved for a three-year period beginning April 1, 1985. To retain the waiver, the department must apply for its renewal. However, HCFA may deny renewal of the waiver and Minnesota would no longer receive federal funds for CAC services. It is necessary and reasonable to specify the effective period of these rule parts related to the waiver in order to inform persons

affected by these rules.

9505.3510 DEFINITIONS.

Subpart 1. **Applicability.** This subpart defines words and phrases that have a meaning specific to parts 9505.3500 to 9505.3700 that otherwise may have several possible interpretations or that must be consistent with statutes and related rules of the department.

Subpart 2. **Acting case manager.** This is a term used in these rules. The definition is needed to set a standard for who qualifies as an acting case manager. The standard chosen is consistent with that set for a case manager in subpart 7 except in regard to how an acting case manager and a case manager are assigned. CAC recipients are chronically ill individuals whose illnesses place them at risk of hospitalization. The medical services they need include those that are the same or similar to medical services provided in a hospital, such as nursing care, rehabilitative therapies, prescribed drugs. Health professionals such as registered nurses and public health nurses are knowledgable about services that may be needed by chronically ill persons. Because they are receiving the health services they need at home, they have some special needs related to their general welfare and care that may have social implications. These needs include being able to communicate effectively about their care, interpersonal needs, dependency on informal caregivers who are properly trained, and being assured that their homes provide a safe environment. Social workers have knowledge and training related to these recipient needs. Thus, it is reasonable to specify that the acting case manager must have the qualifications of a registered nurse, public health nurse, medical social worker, or social worker because these persons are knowledgeable about the health and social needs of chronically ill individuals.

Subpart 3. **Applicant.** The definition is necessary to clarify a term used as an abbreviation in these rules. It identifies persons who have applied for but whose eligibility for CAC services under the waiver has not been determined. The definition is consistent with the waiver.

Subpart 4. **Application.** This is a term used in these rules as an abbreviation for the request to determine an individual's eligibility for home and community-based services as a CAC recipient. A definition is necessary to clarify its meaning. Using an abbreviation is reasonable because it shortens the length of the rules.

Subpart 5. **Assessment.** "Assessment" is a term used in these rules. A definition is necessary to clarify its meaning. The definition is consistent with the waiver which requires an evaluation of the need for home and community based services for medical assistance recipients as part of determining the individual's eligibility for CAC. The definition is also consistent with the waiver requirement that the assessment be carried out by an interdisciplinary team or hospital discharge planning team. (See subpart 27 for the definition of "interdisciplinary team.")

Subpart 6. **Case management services.** "Case management services" is a term used in these rules. A definition is necessary to clarify its meaning. The definition is consistent with the waiver. See Waiver Attachment I, page 1. Consistency with the waiver is reasonable so that the service qualifies for federal financial participation as required by

Minnesota Statutes, section 256B.04, subdivision 4.

Subpart 7. **Case manager.** A definition of "case manager" is necessary to set a standard for this term as used in these rules. The waiver requires case management services to be provided by a "trained professional". See Waiver Attachment I, page 1. Under the waiver, the case manager has responsibilities related to a recipient's care plan. The care plan specifies the recipient's needed health services including home and community-based services. Thus, a case manager needs to have knowledge and skills related to health care and social services. The definition is reasonable because the persons listed within it are expected to have such knowledge and skills as a result of their professional training.

In Minnesota, registered nurses and public health nurses may choose to be independent practitioners of their profession. However, it is necessary and reasonable to require them as case managers to be employed or under contract with the lead agency as this agency is held accountable under the CAC rules for services being provided to the CAC recipient. This accountability has been delegated by the department in order to safeguard the health and welfare of the CAC recipients as required by the waiver. Finally, the definition is consistent with other department rules related to case management for persons receiving home and community services. See part 9505.2395, subpart 10.

Subpart 8. **Chronically-ill individual or individual.** "Chronically ill individual" or "individual" are terms used in these rules. The definition is necessary to clarify their meaning. Chronic illness is characterized by symptoms of long duration or frequent repeated occurrences. The waiver limits eligibility to individuals whose chronic illness is of such severity that the individual would reside in an inpatient hospital or require frequent hospitalization. Examples of such chronic illnesses are certain neurological disorders, spinal cord injuries, birth defects, and certain conditions requiring parenteral feeding or the use of life sustaining equipment such as ventilators. These illnesses require monitoring and treatment by health care professionals that is very costly and often difficult for a medical assistance recipient to obtain any where except in certain hospitals. Thus, the definition is reasonable because it is consistent with the purpose of the waiver, cost containment by enabling necessary services to be provided to the eligible recipient at home. The use of the term "individual" is reasonable as an abbreviation to shorten the rules.

Subp. 9. **Commissioner.** The term "commissioner" is used throughout these rules as an abbreviation for the person responsible under Minnesota Statutes, section 256.01, subdivisions 1 and 2(1), for the administration of the medical assistance program. A definition is necessary to clarify its meaning. Using this term in lieu of "Commissioner of Human Services" is reasonable to delete unnecessary words in a term frequently repeated in the rule. Minnesota Statutes, section 15.06, subdivision 6(1) allows the commissioner to delegate specified duties and powers. Including within the definition the commissioner's designated representative is consistent with the statutory authorization to delegate.

Subpart 10. **Community alternative care program or CAC.** This subpart is necessary to define a term used in these rules. The definition identifies the Community Alternative Care program as the waiver for services to chronically ill individuals that has been approved by the

United States Department of Health and Human Services. The term, community alternative care program, is in common usage and emphasizes that the program is an alternative to institutionalization and is provided in the community. In the program governed by these rules, the program is an alternative to hospitalization. Using the abbreviation CAC is reasonable to shorten the length of the rule. The abbreviation is commonly used by county staff and other affected persons.

Subpart 10a. **Counseling and training services.** This term is used in these rules. A definition is necessary to clarify its meaning and ensure consistency with the waiver. Primary caregivers provide essential services to CAC recipients and are indispensable to the CAC program. However, many primary caregivers, including family members filling this role, have not had previous training and experience in using medical equipment and medical procedures and in coping with stressful situations that arise from the CAC recipient's chronic illness. This definition is consistent with the waiver. Consistency with the waiver is reasonable so as to obtain federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4.

Subpart 11. **County of financial responsibility.** "County of financial responsibility" is a term used in these rules which must be defined to clarify its meaning. The definition is consistent with Minnesota Statutes, chapter 256G, which is cited within it.

Subpart 12. **County of service.** This definition is needed to distinguish between counties of financial responsibility and counties of service. A recipient's county of service may differ from the recipient's county of financial responsibility. When a person lives outside of the county of financial responsibility, the county of financial responsibility may provide service through an agreement with the county in which the recipient resides. For example, a county of service performs case management functions for a CAC recipient who lives outside of his or her county of financial responsibility. This is reasonable because it is administratively efficient; counties may be financially responsible for persons who reside hundreds of miles from the lead agency's office. To require county workers or persons to travel that distance for services would be unreasonable.

Subpart 13. **Department.** This definition is necessary to identify the state agency which is responsible under Minnesota Statutes, section 256B.49, for administration of the waiver. It is reasonable to shorten "Department of Human Services" to "department" to reduce unnecessary words in these rules.

Subpart 14. **Durable medical equipment.** Durable medical equipment refers to certain equipment used by CAC recipients in their homes. The definition is necessary to clarify the term's meaning. The definition is consistent with part 9505.0175, subpart 10, which defines the term for purposes of eligibility for medical assistance reimbursement. Such consistency is required by the waiver which imposes certain medical assistance standards about durable medical equipment on CAC.

Subpart 15. **Environmental modifications in the home.** This definition is necessary to clarify a term used in these rules. Environmental modifications are limited in the waiver to minor physical adaptations to the home which are necessary to allow the recipient to remain at home. See Waiver Attachment I, page 1. The definition is consistent with the

waiver requirements. Consistency with the waiver is reasonable so as to obtain federal financial participation as required by Minnesota Statutes, section 256B.04, subdivision 4.

Subpart 16. **Foster care services.** Foster care services are services available under the waiver. A definition is necessary to clarify the term's meaning. The definition is consistent with the waiver which requires all services or individuals providing services to CAC recipients to meet applicable state licensure requirements. Consistency with the waiver is reasonable so as to obtain federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4. Parts 9545.0010 to 9545.0260 license foster care homes for children; parts 9555.5105 to 9555.6265 license foster homes for adults.

Subpart 17. **Health care professional.** "Health care professional" is a term used in these rules as an abbreviation for several categories of medical personnel who provide health services to medical assistance recipients, including CAC recipients. A definition is necessary to clarify its meaning. The personnel included within the definition are consistent with those specified in the waiver as qualified to provide services to CAC recipients. Parts 9505.0170 to 9505.0475 and part 9500.1070 also authorize medical assistance payment for certain services provided by the personnel within this definition.

Subpart 18. **Health service.** The definition is necessary to clarify a term used in these rules and set a standard. A CAC recipient may receive those health services specified in parts 9505.0170 to 9505.0475 as well as CAC services. Parts 9505.0170 to 9505.0475 set standards governing eligibility for medical assistance reimbursement. The standards in this definition are consistent with the waiver and with parts 9505.0170 to 9505.0475. The standards are: the service is medically necessary, ordered by a physician, documented in an approved care plan, and provided as ordered in the recipient's care plan. It is reasonable to be consistent with other rules of the department affecting the same program in order to avoid confusion and to carry out the requirements of Minnesota Statutes, section 256B.04, subdivision 2 in regard to uniform statewide administration of the medical assistance program.

Subpart 19. **Home.** "Home" is a term used in these rules. A definition is necessary to clarify its meaning. It is reasonable to define the term according to the definition in the rule governing provider services under the medical assistance program because it ensures uniformity in administration of the program as required by Minnesota Statutes, section 256B.04, subdivision 2 and avoids confusion. Clarifying that the term does not include a hospital or long-term care facility is reasonable to insure consistency with the waiver so as to obtain federal financial participation as required by Minnesota Statutes, section 256B.04, subdivision 4.

Subpart 20. **Home and community-based services.** This term is used in the rule and in the waiver as an abbreviation encompassing all services available to a CAC recipient as waivered services. A definition is necessary to clarify its meaning. The definition is consistent with the waiver. The definition is reasonable as it informs affected persons of the services that are available to CAC recipients through CAC funding.

Subpart 21. **Home care plan or care plan.** This definition is necessary to clarify a term used in these rules. The waiver requires a written

plan of care to be developed for each CAC recipient that describes the services to be furnished by the providers. The definition is consistent with the waiver. It is reasonable to use an abbreviation, "home care plan" or "care plan" in place of "individual plan of care" to shorten these rules and to remove possible confusion resulting from the use of similar terms, "individual service plan" and "individual treatment plan", that are used in other medical assistance programs which do not include the home and community-based services specified in the waiver. A written care plan is a reasonable requirement as it is evidence of the CAC recipient's service needs and reduces the possibility of confusion and misunderstanding about these needs.

Subpart 22. **Homemaker.** This definition is necessary to clarify a term used in these rules and to set a standard. The definition is reasonable because it is consistent with the cited rule. See also subpart 24 and its SNR.

Subpart 23. **Homemaker services.** This definition is necessary to clarify a term used in these rule parts and set a standard. Homemaker services can be funded by CAC under the waiver. The definition is reasonable because it differentiates homemaker services from other forms of care that may be funded with CAC, ensures consistency with the cited department rule establishing standards for homemaker services, and is consistent with common understanding.

Subpart 24. **Home health aide.** This definition is necessary to clarify a term used in these rules and set a standard. Home health aides provide specific paraprofessional or non-professional home health services. The definition is reasonable because it is consistent with part 9505.0290, subpart 3, item B which defines "home health aide" for medical assistance payment purposes and thereby avoids confusion between similar services provided by similarly qualified persons.

Subpart 25. **Hospital.** "Hospital" is a term used in the rule that refers only to facilities licensed under Minnesota Statutes, section 144.696. The definition is also consistent with the explanation of methodologies applicable to the program. See Explanation of Methodologies, section 1, which is attached to the December 30, 1987 letter of Assistant Commissioner Gomez. The explanation refers to persons "who reside in, or be at risk of, an acute care hospital."

Subpart 26. **Interdisciplinary team or team.** "Interdisciplinary team" is used in these rules to identify a group of persons who is assigned certain functions under the waiver and these rules. A definition is necessary to clarify its meaning. The waiver specifies two such teams: the hospital discharge planning team and the community interdisciplianry team. The teams are similar in membership and roles but differ depending on whether the person who is an applicant is receiving services in the community or in the hospital and on the person's status in regard to CAC eligibility and need for reassessment. The membership and functions of the teams are specified in part 9505.3535. The definition is consistent with the waiver requirements. Using the term "team" as an abbreviation is reasonable because it shortens these rules.

Subpart 27. **Lead agency.** This definition is necessary to clarify a term used in these rules. The local agency often names one of its own departments to serve as lead agency for CAC administrative purposes if the local agency's department has personnel with expertise in the needs

of persons served by a program or the local agency may name another agency as the lead agency. A local public health agency employs persons who are public health nurses. See the definition of public health nurse in subpart 44 and its SNR. The scope of practice of a public health nurse as set forth in Minnesota Statutes, section 148.171, includes providing a nursing assessment of the actual or potential health needs of individuals and providing referral to other health sources. Thus, a public health agency employing public health nurses has persons who are qualified to assess the service needs of CAC applicants and recipients. Therefore, it is reasonable to include a public health agency within the definition of lead agency because this is a means of assuring that the lead agency has staff qualified to administer CAC.

Subpart 28. **Licensed practical nurse.** "Licensed practical nurse" is a term used in these rules. A definition is necessary to set a standard. The definition chosen is reasonable because it is consistent with Minnesota Statutes, section 148.29 which defines the term "Licensed Practical Nurse" and the scope of practice of the licensed practical nurse. The scope of practice includes services in observing and caring for the ill and in applying counsel and procedure to safeguard life and health and in administering treatment prescribed by physician. The definition also is consistent with the waiver requirement placed on CAC providers to meet applicable state licensing standards.

Subpart 29. **Local agency.** "Local agency" is a term used in these rules. It is defined solely for identification purposes. It is the county or multicounty agency that administers the medical assistance program on a day to day basis subject to the supervision of the Department of Human Services. Subpart 30. **Medical assistance.** It is necessary to identify the particular program governed by these rules that establish conditions of payment of the costs of health services to persons determined eligible for medical assistance. The definition is solely for purposes of identification. Subpart 31. **Medically necessary.** Medical assistance payment for health services is based on the requirement that the service is a health service that is required for the recipient's well-being. Under Minnesota Statutes, section 256B.04, subdivision 15, the department must determine whether a medical assistance service is necessary. It is necessary to define the standard of necessity that determines whether a particular health service is eligible for medical assistance payments. It is reasonable to use the standard of the medical assistance program because the CAC program is funded by medical assistance and the same utilization standards apply. This standard is defined in part 9505.0175, subpart 25.

Subpart 32. **Medical social worker.** "Medical social worker" is a term used in these rules and the waiver. The definition is necessary to clarify its meaning. The definition is consistent with the waiver. Consistency with the waiver is reasonable as a means of obtaining federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4.

Subpart 33. **Nondurable medical equipment.** The definition is necessary to clarify a phrase used in these rules. The American Heritage Dictionary of the English Language defines durable as "able to withstand wear and tear or decay; lasting." "Nondurable" is the opposite of "durable." Therefore, the

definition is reasonable because it is consistent with common usage and clearly distinguishes "durable" from "nondurable."

Subpart 34. **Nursing services.** The definition is necessary to set a standard for a term used in these rules. The definition is consistent with the requirement of the waiver that providers of services to CAC recipients must hold applicable licensures or certifications. Consistency with the waiver is reasonable as a means of obtaining federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4.

Subpart 35. **Nutritionist.** "Nutritionist" is a term used in these rules. A definition is necessary to set a standard. The definition is consistent with the waiver. Consistency with the waiver is reasonable as a means of obtaining federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4.

Subpart 36. **Occupational therapist.** "Occupational therapist" is a term used in these rules. A definition is necessary to set a standard for who is qualified to provide occupational therapy services to recipients. The standard chosen is consistent with the definition specified in the waiver.

Subpart 38. Physician. The definition is necessary to clarify the term used in these rules and note that it is consistent with the statute. Consistency with the statute is reasonable as a means of obtaining federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4.

Subpart 37. **Physical therapist.** Physical therapist is a term used in these rules. It must be defined to set a standard for a person qualified to provide physical therapy services to recipients. It is reasonable to use the state standard for registration as a person qualified to practice physical therapy as this standard meets the waiver provision that CAC providers meet state registration and certification requirements. See Minnesota Statutes, section 148.65 to 148.78.

Subpart 39. **Prescribed drug.** "Prescribed drug" is a term used in these rules. A definition is necessary to clarify its meaning. Minnesota Statutes, section 151.01, subdivision 5 defines the term in the context of pharmacy practice. The definition is reasonable as it is consistent with the statutes regulating pharmacy practice in Minnesota.

Subpart 40. **Primary caregiver.** This definition is necessary to clarify a term used in these rules. The term is one that human service agencies and professionals working in those agencies commonly use to describe a person, usually a family member, who provides without payment informal and volunteer services that the recipient requires for activities of daily living. The definition is reasonable because it is consistent with common practice.

Subpart 41. **Provider.** This definition is necessary to clarify a term used in these rules. It is reasonable to limit the use of the term to those specified in Minnesota Statutes, section 256B.02, subdivision 7 so that this rule establishing standards for a medical assistance program is consistent with the statutory limitation applicable to medical assistance standards. The definition is also consistent with the waiver requirement that "all state licensure and certification requirements for services or individuals providing services will be met." Finally, the definition cites subpart 20 which lists covered provider services. It is necessary

and reasonable to list covered provider services to more accurately identify which providers may be included in the program.

Subpart 42. **Public health nurse.** The definition is necessary to clarify a term used in these rules and to set a standard. The definition is consistent with the cited statutes and certification procedures of the Minnesota Department of Health.

Subpart 43. **Reassessment.** The definition is necessary to clarify a term used in these rules. Before providing CAC services to a recipient, an initial assessment of his or her health service needs and functional abilities is performed. A recipient's needs or resources may change over time and a recipient may require another assessment or redetermination of eligibility for CAC services. The provision is consistent with the waiver. Consistency with the waiver is reasonable as a means of obtaining federal financial participation required under Minnesota Statutes, section 256B.04, subdivision 4. See also part 9505.3545.

Subpart 44. **Recipient.** This is a term used in these rules. A definition is necessary to clarify its meaning. The definition is reasonable because it ensures consistency in use of the term in the CAC program. Using an abbreviation is reasonable to shorten these rules.

Subpart 45. **Registered nurse.** The definition is necessary to clarify a term used in these rules and set a standard. The definition is reasonable because it is consistent with the cited statute.

Subpart 46. **Representative.** The definition is necessary to clarify a term used in these rules. It is reasonable because it is consistent with the cited statutes and with the medical assistance rule that provides for naming of representatives.

Subpart 47. **Respiratory therapist.** This definition is necessary to set a standard for providing respiratory therapy to a CAC recipient. Minnesota does not now provide for registration or licensure of respiratory therapists. Therefore, the standard set in this provision is the one specified in the waiver. It is reasonable to comply with the waiver in order to obtain federal financial participation for the service.

Subpart 48. **Respite care services.** This definition is necessary to clarify a term used in these rules and set a standard. Respite care services can be funded by CAC. The definition is reasonable because it differentiates respite care from other forms of care that may be funded by CAC. The informal care of a recipient may depend on many persons who work together to assure the recipient receives the needed daily services. It might be almost impossible to care for the recipient if any one of the informal caregivers including the primary caregiver is not available. Thus, it is reasonable to include not only the primary caregiver but also the family and other informal caregivers within the definition because respite care during the unavailability of one of these persons may be necessary to provide the CAC recipient's needed services.

Subpart 49. **Social worker.** "Social worker" is a term used in these rules. A definition is needed to clarify the term and to set a standard. The waiver specifies that a social worker of the local agency must be a member of the interdisciplinary team. It is reasonable that a social worker must meet the employment qualifications of the local agency as these standards are adopted pursuant to Minnesota Statutes, section 256.012, and Minnesota Rules, Chapter 9575.

Subpart 50. **Speech therapist or speech-language pathologist.** The definition is necessary to set a standard for a term used in these rules. Minnesota does not now have standards for licensing or registering speech therapists. However, the American Speech-Language-Hearing Association is the national organization that sets professional standards for persons practicing these therapies. Thus a person holding a current certificate from the American Speech/ Language/Hearing Association in evaluation and treatment of speech/language pathologies or who has completed the academic requirements
and is acquiring the supervised work experience holds professional qualifications that are accepted by a national professional organization. The definition is reasonable because this association is the recognized accrediting entity for this profession.

Subpart 51. **Transportation.** The definition is necessary to set a standard. The standard is consistent with the requirements of the waiver in regard to the need for the service, specification in the care plan, and approval by the case manager. It should be noted that part 9505.0140 requires counties to have transportation plans to ensure recipients access to services and that part 9505.0315 specifies certain services as medical transportation services eligible for medical assistance reimbursement. Thus, it is reasonable to limit the definition to services ineligible for medical assistance payment under parts 9505.0010 to 9505.0475 to ensure consistency with the waiver and maximize the availability of CAC funds for non-covered services. Consistency with the waiver is reasonable as a means of obtaining federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4.

Subpart 52. **Waiver.** The definition is necessary to clarify a term used in these rules. The term is consistent with title 42, Code of Federal Regulations, Part 441, Subpart G.

Subpart 53. **Waiver year.** The definition is necessary to clarify a term used in these rules. The waiver is approved for five years. It has differing requirements for specific 12 month periods beginning with its effective date. The effective date is not the same as a federal or state fiscal year, so the term waiver year is needed to distinguish the periods at which new requirements become effective. The definition is consistent with title 42, Code of Federal Regulations, section 405.304 and, therefore, is reasonable.

Subpart 54. **Working day.** The definition is necessary to clarify a term used in these rules. Since the local agency is responsible for implementing the CAC program, either directly or indirectly by designating a lead agency, it is reasonable that the term be limited to the hours when the local agency is open.

9505.3520 ELIGIBILITY FOR COMMUNITY ALTERNATIVE CARE SERVICES.

This part is necessary and reasonable because it clarifies who is eligible for the CAC program and thereby informs affected persons.

Item A requires that the individual be eligible for medical assistance. The waiver requires that participation in the program be limited to individuals who are eligible for medical assistance. This is consistent with the purpose of the waiver which is to save medical assistance funds that would be required to pay for the individual's hospitalization if

home and community services were not available.
Item B requires that an individual meet the age criteria for the program. This is necessary and reasonable because Minnesota Statutes, section; 256B.49, subdivision 1 authorizes providing waivered services to chronically ill or disabled individuals under age 65.
Item C is necessary to inform affected persons of the waiver requirement that all other resources must be used before the CAC program applies. This is reasonable because the CAC funds are then used to supplement other funding sources. Therefore, item C is required by the waiver. The item is consistent with the requirements of part 9505.0070, subpart 2 which requires use of a third party payer to the "fullest extent available before a medical assistance payment is made on the recipient's behalf." See also 42 CFR
435.603 and 435.604 in regard to applications for benefits from and assignment of rights to benefits from third party payers.
Item D is necessary to put parties on notice that the primary care providers, usually family members, must be capable of learning how to deliver the services designated in the care plan as their responsibility and that they must be willing to provide the services. This is reasonable because it is impossible for individuals eligible for CAC to live outside of a hospital unless they receive significant assistance from others. It should be noted that CAC is a family-centered program of coordinated care in the recipient's home. The home and community-based services available through CAC include those designed to assist the family to care for its chronically ill member. The team must determine how best to support the family through CAC services rather than to supplant the family as primary caregiver. In providing this support, the team must consider and balance what the family wants and what the family needs.
Item E is necessary because CAC services are limited to persons who reside in a hospital or are at risk of frequent hospitalization. A physician determines whether it is necessary to admit a person to a hospital. Thus it is reasonable to require that a physician must certify that the person would be hospitalized or frequently admitted to a hospital without CAC services. This item is required by the waiver.
Items F, G, and H are basic eligibility criteria for CAC services under the waiver. Their inclusion in the rule is necessary and reasonable to inform affected persons and to ensure consistency with the waiver requirements. In item H, a definition of the term "third party payer" is necessary to set a standard and avoid confusion. The definition is reasonable because it coordinates this definition with that in the rule generally applicable to determining an individual's medical assistance eligibility. However, modifying the definition in part 9505.0015, subpart 46 for purposes of CAC is reasonable to ensure consistency with the waiver which includes Medicare as a potential third party payer of the costs of CAC services.
Item I is necessary and reasonable to inform affected persons of a limitation specified in the waiver. See letter from William L. Roper, HCFA, and the Waiver Recipient Summary Table, page C of the Worksheet for Equations Submitted with Waivered Services Proposals.

9505.3530 **REQUEST FOR CAC SERVICES.**

Subpart 1. **Who may request service.** This subpart is necessary to inform interested parties that an individual may apply for CAC services on the basis of a belief that he or she meets the criteria. It is reasonable to require the request to be made to the department so that the department can carry out its duties of appointing an acting case manager and providing the necessary forms in a prompt and efficient manner. (See subpart 2.) The department has the responsibility to determine who is eligible for CAC. Therefore, it is reasonable to require the request to be made to the department so that the department has a record of potential applications and can control the use of CAC funds as required under part 9505.3680, subpart 4.

Subpart 2. **Response of department to request for CAC.** This subpart specifies the actions the department must take when it receives a request for determination of eligibility for CAC. Specifying the required actions is necessary because it assures a uniform statewide administration of this medical assistance program as required under Minnesota Statutes, section 256B.04, subdivision 2. It is reasonable to require the department to determine the individual's county of service because the determination will facilitate the appointment of an acting case manager and a case manager who are located in the individual's service area. It also is reasonable to require the department to determine when services are expected to begin because the department must determine the availability of CAC funds within the limitations of the waiver at the expected time of service. (See parts 9505.3520, item G and 9505.3680.) The waiver requires the team planning for the health service needs of an applicant for CAC to include an acting case manager who may be the applicant's primary nurse, medical social worker, county social worker, or county public health nurse. It is reasonable to require the department to designate an acting case manager because the department has the ability to consider the availability of persons with the required qualifications and thereby enable a prompt response to the applicant's request for participation in CAC. Many applicants for CAC services are hospital patients who will require CAC services in order to be discharged from the hospital and reside in the community. Thus, requiring forms to be sent within five working days is reasonable because it enables a prompt response to the applicant's request, benefits the applicant, and is consistent with the waiver's purpose of enabling the individual to live in the community. Requiring the department to notify the local agency if an acting case manager who is not an employee of the local agency is designated is reasonable as the local agency will be responsible for designating the individual's ongoing case manager and the lead agency. See subpart 3 and part 9505.3640, subpart 2.

Subpart 3. **Local agency designation of team members.** This subpart is necessary to specify the responsibility of the local agency when it receives the department's notice about the request for a determination of eligibility for CAC. It is reasonable to require the local agency's designation of team members to be no later than five working days after receiving the notice as a prompt designation benefits the applicant and assures that a qualified person will be available to provide ongoing case management under CAC.

9505.3535 INTERDISCIPLINARY TEAMS; ESTABLISHMENT AND MEMBERSHIP

Subpart 1. **Applicant's interdisciplinary team.** This subpart sets the standard for membership on the interdisciplinary team. A standard is necessary to comply with the requirement of uniform statewide administration of the medical assistance program as specified in Minnesota Statutes, section 256B.04, subdivision 2. Requiring the acting case manager to form the interdisciplinary team is consistent with the case manager's responsibilities, under the waiver, to coordinate services and to provide the individual with information about care choices, available services, and rights. The persons specified in items A to K are consistent with the requirements of the waiver. See Waiver Attachment V, in regard to "obligatory discharge planning team members". It should be noted that the membership in items A to J is obligatory but that the team may have representatives from other services that are required by the applicant's medical condition. Such representation is consistent with the waiver which states that "...membership will depend on the individual's specific service needs...." It is reasonable to include the applicant as a team member to ensure consistency with the waiver, and to assure that the applicant is present to provide the information needed by the team and to obtain information about the applicant's rights and responsibilities. It assures that the applicant has information from the beginning that he or she needs to make an informed choice to complete the process of applying for CAC. Because of the nature of their disabilities, some applicants may not be able fully to participate in the team's discussion. Some applicants are minors. These applicants need to be represented on the team by a person who can act for them. It is therefore reasonable to provide that the applicant's representative be a member of the interdisciplinary team because the representative who has the responsibility or legal authority to act for the applicant. See the definition of representative in part 9505.3510, subpart 46.

Subpart 2. **Interdisciplinary team; reconvened.** This subpart specifies who will serve on the interdisciplinary team of a person who is living in the community. The subpart is necessary to ensure consistency with the waiver which names a membership for this purpose which is different from the membership in subpart 1 and which will develop and implement a community service program based on the individual plan of care developed by the team specified in subpart 1. Items A to H are consistent with the requirements of the waiver. (See Waiver Attachment V, page 3.) It is reasonable to require the case manager to assure continuity of service of team members because their continued participation ensures the availability of persons knowledgable about the recipient's condition and needs and avoids burdening the CAC recipient with the need to adjust to new team members. Permitting the team to include other health care professionals who provide services required by the recipient's medical condition (Item I) is consistent with the waiver. It is reasonable to include the recipient as a team member because his or her participation assures that the recipient has information needed to make choices about service providers and continued participation in CAC. Because of the nature of their disabilities, some recipients may not be able fully to participate in the team's discussion. Some recipients are minors. These recipients need to be represented on the team by a person who can act for

them. It is therefore reasonable to provide that the recipient's representative be a member of the interdisciplinary team because the representative who has the responsibility or legal authority to act for the recipient. See provisions concerning free choice, at part 9505.0190 and 42 CFR 431.51.

9505.3540 INTERDISCIPLINARY TEAM RESPONSIBILITIES; ASSESSMENT.

Subpart 1. **Assessment of applicant's service needs.** This subpart specifies one of the assessments that an interdisciplinary team must perform. A standard is necessary to comply with the requirement of Minnesota Statutes, section 256B.04, subdivision 2 to administer the medical assistance program in a uniform statewide manner. The assessment of the applicant's need for home and community-based services is required by the waiver. It is reasonable that the assessment be on forms provided by the commissioner because use of these forms ensures that data will be collected uniformly throughout the state and thus the department's determination of eligibility for CAC is made on a uniform and equitable basis. See Minnesota Statutes, section 256B.04, subdivision 2.

Subpart 2. Assessment of financial resources. Assessment of the applicant's financial resources is consistent with the requirement that participation in CAC is limited to individuals who are eligible for medical assistance. See Model Waiver Request, page 3, paragraph 3 and Minnesota Statutes, section 256B.49. Requiring the team to assess the applicant's financial resources is reasonable because the team has direct access to the applicant or the applicant's representative and thus is in the best position to collect the required data. Requiring the team to use forms supplied by the commissioner is consistent with the requirement of Minnesota Statues,
section 256B.04, subdivision 2, that the department administer the medical assistance program statewide in a uniform manner.

Subpart 3. Assessment of the applicant's home. This subpart is necessary to specify a uniform standard of assessment of an applicant's home. Applicants for CAC services because of the severity of their chronic illnesses or disabilities have many health and health related needs. Under the waiver the department is required to take necessary safeguards to protect the health and welfare of the CAC recipients. See Model Waiver Request, paragraph 10 (a). The condition of an applicant's home directly affects an applicant's health and welfare. One part of the assessment will identify environmental modifications in the home that are needed to operate medical equipment required by the applicant or to assure the applicant's mobility within the home. Other parts of the assessment review safety factors such as electrical equipment and proper storage of medical supplies and adequacy of heating, cooling, and bathroom facilities. See Waiver Appendix C. Thus this subpart is necessary and reasonable because it assists the department to collect data related to safeguarding the health and welfare of CAC recipients. It is reasonable to require the team to complete the assessment as the team has direct access to the applicant and the applicant's representative and is responsible under subpart 8 to recommend the services the applicant needs. Requiring the team to use forms supplied by the commissioner is consistent with the requirement of administering the medical assistance program statewide in a uniform manner according to

Minnesota Statutes, section 256B.04, subdivision 2.

Subpart 4. **Assessment of person to be primary caregiver.** CAC is designed to provide home and community based services to individuals who are chronically ill and at risk of hospitalization. This population has multiple health service needs. Many individuals require complex services such as suctioning, gastric feedings, assistance with bowel and bladder functions, ventilation, and intravenous therapy. The primary caregiver may be unable to provide actual hands on care in regard to these services but nevertheless the primary caregiver is responsible to make sure the recipient receives the services. The primary caregiver also provides parenting and back-up services and advocates on behalf of the recipient. Thus the primary caregiver is essential to the CAC program and a recipient's CAC eligibility. Additionally, some CAC applicants may fall within the definition of vulnerable adults under Minnesota Statutes, section 626.557 subdivision 2, paragraph (b). Others are children who may be subject to physical or sexual abuse or neglect as defined in Minnesota Statutes, section 626.556, subdivision 2, paragraphs (a), (c), and (d). The waiver requires the department to take necessary safeguards to protect the health and welfare of CAC recipients. An assessment of the ability and the willingness of a person to serve as a primary caregiver provides the department information related to maintaining the applicant in a safe environment and helps the department in determining that services essential to the CAC applicant's eligibility are available. Thus, this subpart is necessary to comply with the waiver. It is reasonable to require the team to make the assessment as the team has direct access to the applicant, has expertise about services needed by chronically ill individuals, and is responsible under subpart 8 for recommending the applicant's needed services. It also is reasonable to require the team to use forms supplied by the commissioner as this requirement assures administration of the medical assistance program statewide in a uniform manner. See Minnesota Statutes, section 256B.04, subdivision 2.

Subpart 5. **Authorization to release information.** It is necessary for members of the team to have access to information about an applicant. The information makes the team fully aware of factors affecting the applicant. Thus, when the team makes its recommendations about the applicant's appropriate services, the recommendations will assure that applicant receives or has access to services that are necessary and appropriate, that the applicant's services are coordinated, and that duplication of services is avoided. At the same time, the applicant's right to privacy is protected as required by the Minnesota Data Practices Act, Minnesota Statutes, Chapter 13. Obtaining authorization is required by the Minnesota Government Data Practices Act, Minnesota Statutes, Chapter 13. It is necessary to specify who is to obtain an authorization to release information in order to have a clear procedure and avoid confusion. Requiring the team to obtain the authorization is reasonable as the team has direct access to the applicant or the applicant's representative and can obtain the authorization in an administratively efficient manner. Under Minnesota Statutes, section 13.42, some medical information is medical data (medical records) and is private and may be released only to the subject of the data unless the subject has given an "informed consent" to authorize disclosure as required under Minnesota

Statutes, section 13.05, subdivision 4 (d). Release of other types of medical and financial information and welfare data is not covered by Minnesota Statutes, section 13.05, subdivision 4 (d) but it is reasonable to request the applicant or the applicant's representative to authorize access to this information because such a request protects the right of the applicant or the applicant's representative to make an informed choice whether to authorize access. This subpart therefore specifies the items of information that must be on the form an applicant or, when it is appropriate, the applicant's representative signs to authorize release of information. Minnesota Statutes, section 256B.04, subdivision 3 requires the department to prescribe the form of, print, and supply to county agencies such forms as it may deem necessary for the administration of medical assistance. Minnesota Statutes, section 256B.04, subdivision 2 requires the administration of the medical assistance program in a unifrom statewide manner. Therefore, it is consistent with statute and reasonable to require the team, acting on the designation of the local agency to obtain the authorization on a form supplied by the commissioner. Requiring a separate form to be completed and signed for each authorization is necessary and reasonable to avoid confusion and inform the applicant or the applicant's representative authorizing the release and the person or persons who provide the information. Limiting the authorization to one year is consistent with Minnesota Statutes, section 13.05, subdivision 4 (d) (7) which requires a specific statement as to the expiration date of the authorization "which should be within a reasonable period of time, not to exceed one year...."
Items A to E are necessary and reasonable because they specify the information being requested. Item F is necessary and reasonable because it states how the information will be used and enables the applicant or the applicant's representative to make an informed decision. Item G is necessary and reasonable because it safeguards the recipient's privacy by limiting access to a definite period of time.
Subpart 6. **Rights, appeals and freedom to choose.** This subpart requires the teams to give the applicant or the applicant's representative written information concerning certain rights. This subpart is necessary to set a standard to protect the rights of the applicants and avoid misunderstanding. The subpart is consistent with Minnesota Statutes, section 256.045 in regard
to the applicant's or recipient's right to appeal. It also is consistent with 42 CFR 431.200 to 431.246. It is reasonable to require the team to give the information as the team has direct access to the applicant or the applicant's representative and thus can carry out the task in an administratively efficient manner. It is reasonable to require the team to document compliance with this subpart by signing and submitting forms to the department as the signed forms are evidence and provide an audit trail.
Subpart 7. **Development of a care plan.** This subpart specifies who is to develop the applicant's care plan and when it must be submitted to the department. The subpart is necessary to set a standard, assure administration of CAC statewide in a uniform manner, inform affected persons, and avoid confusion. It is reasonable to require the team to develop the care plan as the team has the information and expertise necessary to determine the services that are necessary and appropriate

for the applicant, the appropriate service environment, and the availability of a qualified primary caregiver. Placing the responsibility on the team is also consistent with the waiver. See page 2 of Waiver Attachment V. It is also reasonable to require the development of the care plan according to the information obtained in subparts 1 to 5 as this information is directly related to the applicant's health status, necessary and appropriate services for the applicant, and the applicant's safety and welfare.

Obtaining all the required information may take longer than customary for reasons beyond the team's control. On the other hand, the commissioner who reviews the application for approval and who has to determine whether the applicant's services fall within the waiver's fiscal constraints needs to receive the completed application in a timely manner in order to set priorities within fiscal constraints. Therefore it is necessary and reasonable to require notice to the commissioner if completing the care plan and required assessments will require more than the customary time. Requiring notice if the time extends the requirements of part 9505.0090, subpart 2, or with other rules of the department regarding eligibility for medical assistance program. Requiring the care plan to be signed by the applicant or, if appropriate, the applicant's representative, the applicant's physician, and the acting case manager is reasonable because it provides evidence that these persons have had an opportunity to review and approve the plan.

Subp. 8. **Contents.** The care plan has to contain the services needed by the recipient to remain in his or her home. See part 9505.3510, subpart 21 for a definition of "care plan". Subpart 8 is necessary to establish a standard and to comply with the requirement of uniform statewide administration of the medical assistance program established in Minnesota Statutes, section 256B.04, subdivision 2. The waiver prescribes the development of a care plan that includes the medical and all other services to be provided to the recipient, their frequency and duration, and the type of providers who may furnish these services. See Waiver Attachment V, page 2. Also see Waiver Appendix A which is the form listing the services neccessary to care for the individual in the community. Items A to D of subpart 8 specify the types of information that the team must include. These items are necessary so that the department will be able to determine whether all necessary home and community services are available to the person, whether the person can be maintained in his or her home, whether the person is eligible for CAC and whether the person or the preson's representative, physician, and case manager have approved the plan. Additonally the information is necessary and reasonable because it enables the department to carry out its obligation under the waiver to assure that the services necessary for the person can be provided within the cost limitations of the waiver. See part 9505.3520, items F to H and their SNRs. It is reasonable to require that the plan be on forms provided by the commissioner so that the commissioner receives the information necessary to determine the applicant's eligibility for CAC and also complies with the uniform administration requirement of Minnesota Statutes, section 256B.04, subdivision 2.

Item A is necessary to specify a responsibility of the team. The item is reasonable because it uses as the basis for obtaining the team's

recommendation to approve the eligibility criteria set forth in the cited rule part. This item is reasonable because it informs affected persons of a waiver requirement.

Item B specifies information which the commissioner needs to determine whether to approve CAC services for the applicant. This information includes the portion of the cost of the applicant's health services that will be paid by medical assistance and third party payers to enable a comparison with the limitations on the use of CAC funds (subitems 7, 8, and 9), the parameters for the provision of necessary and appropriate services (subitems 1,2, and 4), and the safeguards of the health and welfare of the applicant (subitems 2 and 3). Subitem 5 assists the commissioner in setting priorities for the use of available funds. Subitem 5 requiring the plan to contain information about emergency backup services is reasonable because it provides the department a further opportunity to evaluate whether the recipient's health and safety will be protected under community-based services. The item is consistent with the waiver requirements.

Item C provides evidence that the team has met the medical assistance requirement of allowing the individual or the individual's representative the freedom to choose from among qualified providers. This item is consistent with the waiver, part 9505.0190, and with 42 CFR 431.51 which provides the recipient's free choice of any qualified medical assistance provider.

Item D is required by the waiver. Its inclusion in the rule is reasonable because it informs affected persons.

Subpart 9. **Team recommendation.** This subpart specifies a responsibility of the team when it has completed the required assessments and care plan. The subpart is necessary to set a standard and avoid confusion about what is expected of the team following completion of an assessment and the care plan. The subpart is consistent with the waiver which specifies the choices as those listed in this subpart. See Waiver Attachment V in regard to the assessment process of the hospital discharge planning team and Waiver Appendices A and B. It is reasonable that the recommendation be supported by the assessments because the assessments contain information needed to determine whether an applicant can safely be maintained outside a hospital setting. Implementation of a recommendation inconsistent with the assessment data might endanger the health or safety of an applicant. It is reasonable that the applicant's physician, the acting case manager, and the applicant or the applicant's representative sign the application as their signatures provide evidence that they had an opportunity to review and approve the care plan.

Subpart 10. **Transmittal of plan, assessments, and recommendations to the commissioner.** This subpart specifies the documents that must be submitted to the commissioner for a determination of the applicant's eligibility for CAC. The subpart is necessary to set a standard, avoid confusion, and assure compliance with Minnesota Statutes, section 256B.04, subdivision 2 in regard to administering the medical assistance program statewide in a uniform manner. The documents required to be submitted provide information about the applicant's health status, need for services, availability of a primary caregiver, and the suitability of the applicant's home as a service site. They also provide evidence that the applicant or the applicant's representative had an opportunity to

review and approve the recommendations and the care plan. Thus, items A to E are reasonable because they are consistent with the waiver requirements. See Waiver, section 4440, items 6 to 10.

9505.3545 REASSESSMENT BY INTERDISCIPLINAARY TEAM.

Subpart 1. **Reassessment required.** This subpart specifies when a redetermination must be made of whether a CAC recipient continues to qualify for home and community-based services under CAC. Several factors may affect the CAC recipient's continued CAC eligibility. They include a termination of medical assistance eligibility, a change in the recipient's health status such that home and community-based services are no longer appropriate and the recipient requires hospitalization, the inability of the primary caregiver to continue to give the necessary care, and an improvement in the recipient's health status to the extent the recipient is no longer at risk of hospitalization. Thus, this part is necessary to set a standard for the time and procedure of reassessing the CAC recipient's continued need and eligibility for home and community-based services. Conducting the reassessment at least once every six months is consistent with the waiver requirement. See Waiver Attachment I, page 1, Case management and also Waiver Attachment V, page 3. Requiring the reassessment to be carried out by the interdisciplinary team convened by the recipient's case manager is consistent with the waiver. See Waiver Attachment V, page 3. The items specified in part 9505.3540, subparts 1 to 9 relate to the recipient's medical assistance eligibility status, continued need for and appropriateness of home and community-based services, the suitability of the recipient's home as a service site, and the willingness and ability of a family member to serve as a primary caregiver, and finally the team's recommendations. It is reasonable to require these assessments and recommendations as part of the reassessment process because they provide the information necessary to determine eligibility for CAC. Requiring the team to review and, if necessary, modify the CAC recipient's care plan is reasonable because it assures that the recipient's health and welfare will be safeguarded as required by the waiver.

Subp. 2. **Responsibility to assure reassessment.** This subpart clarifies that the local agency is responsible to assure the completion of the recipient's required reasssessment. It is necessary to clarify the responsibility in order to set a standard and avoid confusion. Placing the responsibility on the local agency is reasonable as it is the local agency to whom the department has delegated the responsibility for providing CAC services to recipients. As stated in the SNR of subpart 1, the waiver requires a reassessment to be carried out at least every 6 months while a recipient is receiving home and community-based services as part of the redetermination of the recipient's continued eligibility for CAC. CAC funds may only be used to pay for services to persons who are eligible for CAC. Thus, it is necessary to assure completion of the reassessment in a timely manner so that necessary services are provided to the recipient. It is also necessary to assure continuation of the recipient's services will not be affected by a local agency's failure to comply with the required reassessment. Therefore, it is reasonable to hold the local agency
responsible for paying for the services in the recipient's care plan, if

the reassessment is not completed, as the payment assures continuation of the services needed by the recipient and encourages the local agency to comply with the requirement.

9505.3550 **RECIPIENT'S TERMINATION FROM CAC.**
This part is necessary to clarify the circumstances in which a recipient will be terminated from CAC. Item A is reasonable because it is consistent with the recipient's right to choose. See part 9505.0190 and 42 CFR 431.51. Item B is reasonable because it avoids an unnecessary use of CAC funds and a CAC slot which are limited by the waiver and may be needed by another person. A recipient's condition may change to the extent that home and community-based services are insufficient to meet his or her health needs. As a result, the recipient may have to be admitted to a hospital. It may be uncertain how long the recipient will have to be in the hospital or whether home and community-based services will be sufficient to enable the recipient to return home and receive home and community-based services. Item C is reasonable because the recipient's condition requires an uncertain length of continued hospitalization. It is reasonable to require the recipient's physician to certify the recipient's continued need for hospitalization as the physician is responsible for the recipient's hospital services and has firsthand knowledge of the recipient's condition, treatment needs, and response to treatment. Item D is reasonable because if the hospitalized recipient needs services that are not available in the community the department cannot carry out its required obligation to safeguard the recipient's health unless the recipient stays in the hospital. Item E is reasonable as CAC services are only available to a person who is eligible for medical assistance. Items F and G are reasonable because they are consistent with the waiver requirement that home and community-based services provide a cost effective alternative to hospitalization.

9505.3560 **CASE MANAGEMENT SERVICES.**
Subpart 1. **Required service.** This subpart specifies that case management is a required service to a CAC recipient. This subpart is necessary to inform affected persons of waiver requirements related to the case manager's responsibilities. See Waiver Attachment V, page 2.
Subpart 2. **Designation of case manager.** Under part 9505.3530, subpart 2, an acting case manager is designated by the department when the department receives a request for participation in CAC. The acting case manager carries out responsibilities related to completing the assessments and documents required for a determination of the applicant's eligibility for CAC services. If the applicant is determined eligible for CAC, it is necessary and reasonable to designate a more permanent case manager to assure continuity of the case management services required under the waiver and these rules. This subpart requires the lead agency to appoint a case manager. This subpart, therefore, is necessary to clarify which agency is responsible to designate the CAC recipient's case manager. It is reasonable to require the lead agency to designate a recipient's case manager because the lead agency is responsible for the CAC recipient's CAC services. It also is reasonable to require the lead agency to consult with the CAC applicant or the applicant' representative in designating the case manager because the

consultation is consistent with the applicant's freedom of choice. See part 9505.0190 and 42 CFR 431.51. Specifying the time within which the lead agency must designate a case manager is necessary because a timely decision based on information gathered by the case manager must be made about the applicant's request and need for CAC services. Five working days is reasonable because it balances the applicant's need and the workload of the lead agency. The waiver requires that the case manager must not have a financial interest, other than employment by the county responsible for the applicant's CAC services, in the services provided to the applicant. Including this requirement in the rule is reasonable because it informs affected persons. See Waiver Attachment I, Case Management.

Subpart 3. **Case manager responsibilities.** Items A to Q are needed to clarify the responsibilities of a case manager in securing cost effective services appropriate to the recipient's needs and assuring coordination of the services. The responsibilities are consistent with waiver requirements. See Waiver Attachments I and V. Item Q is necessary to clarify that the care plan requires approval by the person who needs the services specified in the care plan (the applicant or CAC recipient) and by the person responsible for ordering health care services for the applicant or CAC recipient (the physician). The item is consistent with the waiver which states that the "patient care plan must be approved in writing by the case manager, individual's parent/spouse or local guardian and attending physician." See Waiver Attachment V. Consistency with the waiver is reasonable because it is required to obtain federal financial paritipation as specified under Minnesota Statutes, section 256B.04, subdivision 4. The item also is reasonable because the signature is evidence that the person has had an opportunity to review the material above the person's signature. It is necessary to clarify the consequences of failing to sign the care plan in order to set a uniform statewide standard as required by Minnesota Statutes, section 256B.04, subdivision 2 and to inform affected persons. An opportunity to review the care plan offers a CAC recipient or applicant, or the representative of the CAC recipient or applicant, a chance to discuss the contents of the care plan with the case manager or acting case manager. The person may be apprehensive about or need reassurance about the nature of the services or about the service providers. The person may request that the care plan specify a different provider or may provide information about past experiences with the service providers. Providing ineligibility for CAC services as a consequence of failure to sign the care plan is reasonable because it ensures that the CAC recipient or applicant agrees with the plan and can reasonably be expected to assist its implementation. It also is reasonable to require the acting case manager or case manager, as appropriate, to request the signature and explain the consequences of failing to sign as this person has direct contact with the applicant or recipient and thus the procedure is administratively efficient.

Subpart 4. **Case manager reports about suspected abuse of a vulnerable adult.** CAC services are provided to recipients who live in the community alone or with their family members. These settings and the provision of services to CAC recipients may not be supervised on a daily basis by qualified professionals. CAC recipients may be vulnerable because of

their own physical or mental health status or because they depend on

others for services. Circumstances may occur under which these recipients may be abused, neglected, or otherwise at risk. Recipients must receive services under safe, healthful conditions. The waiver requires the department to safeguard the health and welfare of CAC recipients. See Waiver Section 4440, item 10 (a). Therefore, it is necessary and reasonable to require the case manager to act to protect the recipient and arrange the necessary services. This part is necessary to specify the procedure the case manager must follow if he or she has reason to believe a recipient is subject to abuse or neglect, or that the health or saftey of a recipient is otherwise at risk. Minnesota Statutes, section 626.557, governs the reporting of maltreatment of vulnerable adults. Some CAC recipients are vulnerable adults as set forth in subdivision 2, clause (c) of this statute. Subdivision 2, clauses (d) and (e) of the cited statute define abuse and neglect as related to a vulnerable adult. Minnesota Statutes, section 626.577 also specifies the requirements for reporting and investigating suspected abuse of vulnerable adults. This part is consistent with the statute cited. It is also necessary and reasonable that the case manager request a report from the protection agency in order to take appropriate actions to ensure the health and welfare of the recipient because the report describes the nature and extent of the problem faced by the recipient in the setting.

Subpart 5. **Case manager reports about suspected abuse of a child.** Some CAC recipients are children. They are unusually vulnerable to neglect or abuse because of their disabling conditions. Minnesota Statutes, section 626.556, subdivision 3, requires professionals of the healing arts, social services, hospital administration, or law enforcement to immediately report information concerning abuse or neglect to the local welfare agency, police department or the county sheriff. This subpart informs case managers about the actions they must take if they suspect abuse of a CAC recipient who is a child. This subpart is consistent with the waiver requirement that the department assure the health and welfare of CAC recipients. It is reasonable to require the case manager to make such reports and to cooperate with the responsible county authority as the case manager must coordinate and arrange the services specified in the recipient's care plan and also meet with the recipient or the recipient's representative in the recipient's residence as necessary to assure the recipient's safety and welfare. See subpart 2, items E and H. The subpart is consistent with Minnesota Statutes, section 626.556, subdivision 3 which sets forth the procedure for reports of suspected child abuse. It is also necessary and reasonable that the case manager request a report from the protection agency in order to take appropriate actions to ensure the health and welfare of the recipient.

Subpart 6. **Other actions required of case manager.** This subpart specifies the action the case manager must take when he or she received the findings of the investigation of a case of suspected abuse. The subpart is necessary to clarify appropriate actions and inform affected persons of their responsibilities. Safeguarding the health and welfare of the CAC recipient is a responsibility of the recipient's case manager.

Therefore, it is necessary and reasonable to require the case manager to determine if a reassessment of the recipient and a revision of the recipient's care plan is required to carry out this responsibility. The examples are actions that may be necessary to protect the recipient's health and welfare. If the provider has harmed the recipient, arranging for another CAC provider is necessary and reasonable because the service is still required but a new qualified provider is needed. Working out another living arrangement for the recipient is a reasonable choice if the harm has occurred in the current residence but the recipient is still able to live in the community. Amending the care plan is reasonable because the amendment process involves a determination of the services required by the CAC recipient and, thus, benefits the recipient by safeguarding the recipient's health and welfare. These actions are consistent with the waiver. Finally it is reasonable to require the case manager to forward the care plan to the commissioner for approval because the waiver gives the commissioner the ultimate responsibility for safeguarding the recipient's health and welfare and for determining the eligibility of the recipient to participate in CAC.

9505.3570 HOME HEALTH SERVICES

This part clarifies the recipient's eligibility to receive the home health services available to all medical assistance recipients. It also clarifies the limits on amount, duration, and scope applicable to these services when they are provided to a CAC recipient. The part is necessary to inform affected persons of the appropriate standard. The limits specified in this part are consistent with the terms of the waiver. See Waiver Attachment I, Home health services, in regard to exemption from the limits on amount, duration, and scope of all medical assistance services.

9505.3575 HOMEMAKER SERVICES

Subpart 1. **Eligibility for service.** This part defines who is eligible for homemaker service. The part is necessary to set a standard. The waiver in Waiver Attachment I requires that homemaker services be provided only when "the individual regularly responsible for these activities is temporarily absent or unable to manage them for himself or others." This subpart is consistent with the waiver.

Subp. 2. **Homemaker services provider; lead agency or contractor.** This subpart informs affected parties that the lead agency, as one of its duties in the CAC program, has the responsibility to provide or contract for homemaker services for CAC recipients. Part 9565.1300 sets out the responsibilities of the local agency for purchasing and supervising homemaker services. Under CAC the local agency has designated the lead agency as the entity to adminster the program. It is reasonable to require the lead agency to adhere to the same standards as the cited rule to ensure uniformity in provision of services. However, a lead agency may contract for homemaker services rather than provide them directly. In this case, the provision of Minnesota Statutes, sections 144A.43 to 144A.46 set the requirements that the provider must meet. This subpart is consistent with the applicable rule and statute.

Subp. 3. **Homemaker service standards.** This subpart sets the

standard applicable to homemaker services. A standard is necessary to comply with Minnesota Statutes, section 256B.04, subdivision 2 which requires uniform, statewide administration of the medical assistance program. Parts 9565.1000 to 9565.1300 define homemaking service and establish the service standards. Requiring homemaker services under CAC to comply with existing state service standards is consistent with the waiver and is reasonable because it ensures coordination of department rules affecting the same service and avoids confusion.

9505.3580. RESPITE CARE SERVICES.

Subpart 1. Eligibility for service. This subpart sets the standard of eligibility to receive respite care services. A standard is necessary to comply with the requirement of uniform statewide administration of the medical assistance program set forth in Minnesota Statutes, section 256B.04,

subpart 2. The waiver in Waiver Attachment I specifies the purpose of respite care as relieving "the family of the care of a dependent person for short, specified periods of time" during the absence of the primary caregiver or during an emergency. The subpart is consistent with the waiver. Waiver Attachment VI, Home Care Costs, specifies 30 days as the maximum number of units of respite care a recipient may receive per waiver year. Respite care may be given on a round-the-clock basis or may be given for shorter periods according to the needs of the primary caregiver. Thus, the limitation may be stated as 720 hours per waiver year as a way to assure that all CAC recipients are treated equitably. The subpart is consistent with the waiver.

Subpart 2. **Provider standards.** The waiver in Waiver Attachment I specifies who is qualified to provide respite care and the setting in which it may be given. The waiver states that it "may be provided in the home by a registered professional nurse, or public health nurse, in the hospital or SNF facility..." The waiver also states that a provider must meet applicable state licensure and certification requirements. A facility giving respite care is an example of such a provider. This subpart is necessary to set standards for respite care and to inform affected persons of the standards. Item A requires a facility providing respite care to be one that meets state licensure standards. The requirement is consistent with the waiver. State licensure standards set the minimum requirements necessary to assure the safety and well being of persons residing in the licensed facility. Thus, item A is reasonable because it assures the safety and well being of CAC recipients and the provision of their necessary services while they are receiving respite care. Requiring such a facility to be one approved by the lead agency is reasonable because the lead agency has been delegated the responsibilities of contracting for and monitoring the recipient's CAC services and of safeguarding the recipient's health and welfare. Item B is consistent the waiver. Requiring the person providing respite care services to act in the place of the primary caregiver and to be available throughout the primary caregiver's absence is reasonable because it assures the recipient will receive the needed services customarily provided by the primary caregiver and thereby protects the recipient's health and welfare.

Subpart 3. **Contract required.** The waiver requires that a facility,

agency or individual provider of respite care services have contracts with the lead agency, and that the lead agency monitor contract performance. This subpart is necessary to inform affected persons of a waiver requirement. The lead agency has been delegated the responsibility of contracting for and monitoring the recipient's CAC services. As part of the contracting procedure, the lead agency sets the standards for performance in the contract and, thus, is in a position to evaluate whether the standards are met. The subpart is consistent with the waiver.

9505.3585PHYSICIAN SERVICES.
This part is needed to set a standard and to inform interested persons of the standard applicable to physician services to a recipient. Part 9505.0345 sets the standard for eligibility for medical assistance payment of physician services. It is reasonable to have one standard applicable to the medical assistance program in order to avoid confusion and to maintain a consistent level of services. The waiver requires services covered by CAC to be provided as necessary to ensure the recipient's health and safety and to be specified in the recipient's care plan. The part is consistent with the waiver. See Waiver Attachment I.

9505.3600 COUNSELING AND TRAINING SERVICES.
Subpart 1. **Eligibility to receive counseling and training services.** Counseling and training for primary caregivers are CAC services available to CAC recipients under the waiver. They include counseling for primary caregivers about "issues pertaining to maintenance of the individual in the home setting and training in the use of equipment and treatment regime as indicated in the plan of care..." This subpart is necessary to inform affected persons of a service available under CAC. It is consistent with the waiver. See Waiver Attachment I. A definition of the terms "member of the recipient's family" or "family member" is necessary to clarify the terms' meaning and establish who is eligible to receive the training and counseling. The persons included in the definition are those who may reside in the same setting as the recipient and serve as the recipient's primary caregiver. Thus the definition is reasonable because it is consistent with the purpose of the service which is to assist "family functioning to maintain the individual at home."
Subpart 2. **Purpose of training.** The waiver specifies that training is related to "the use of equipment and treatment regime as indicated in the plan of care.....; with updates as necessary to maintain safe care of the individual in the home setting." This subpart is necessary to inform affected persons of the waiver provisions applicable to training services. The subpart is consistent with the waiver. It is necessary and reasonable to exclude persons who are employed to care for the recipient from those who will receive CAC funded training and counseling because the agency that employs these persons to care for a CAC recipient is responsible for training or counseling its employees and the cost of the training is included in the provider's contract.

Subpart 3. **Purpose of counseling.** The waiver states that counseling for family members is for issues pertaining to the maintenance of the individual in the home setting and may include "crisis, family and individual counseling and would be assessed as required for family

functioning to maintain the individual at home." This subpart is necessary to inform affected persons of the waiver standard which must be followed to receive payment as a CAC service. It is consisent with the waiver. See Waiver Attachment I.

Subpart 4. **Case manager approval required.** The waiver in Waiver Attachment I requires that "counseling for family members" be approved by the recipient's case manager as a condition of eligibility for CAC reimbursement. This subpart is necessary to inform affected persons of the waiver requirement. Requiring documentation of the service is necessary and reasonable because it provides evidence the case manager has had an opportunity to review the need for and the scope, duration, and amount of the service and it is consistent with the waiver. It also is reasonable because the case manager's review for purposes of determining whether to approve the family counseling affords an opportunity to prevent possible overutilization or inappropriate use of the service as required under Minnesota Statutes, section 256B.04, subdivision 15.

Subpart 5. **Eligibility to provide counseling and training.** The waiver states that counseling and training "will be provided by a county social worker, a medical social worker, the individual's physician, a registered professional nurse, or a public health nurse." This subpart is necessary to inform affected persons of the standard which must be met to receive payment as a CAC service. The subpart is consistent with the waiver. Family members and primary caregivers may have little or no training and
experience in the use of equipment and treatment regimens required by a recipient. Under the waiver, family members usually are CAC recipients' primary caregivers. A determination of their competency to use equipment and treatment regimens is necessary and reasonable to assure the health and safety of recipients. Requiring the person providing the training service to determine whether the person being trained is competent to provide the service required tp maintain the recipient at home is reasonable because the trainer is qualified by experience and training to know what is necessary, has observed the ability of the family member to use the equipment and treatment, and is in the best position to judge the family member's competence to give the service. See Waiver Attachment I.

9505.3610 ENVIRONMENTAL MODIFICATIONS IN THE HOME.

Subpart 1. **Eligibility for service.** The purpose of CAC services is to maintain the CAC recipient in a home setting and avoid hospitalization. The recipient's home may not be constructed, designed, engineered, or arranged to permit the recipient's use of the equipment the recipient needs to live in a home setting. Therefore, the waiver permits physical adaptations to the recipient's home when these adaptations or environmental modifications are indicated in the recipient's plan of care. This subpart is necessary to inform affected persons of the standards applicable to environmental modifications in the home as a condition of eligibility for payment as a CAC service. Items A to D are consistent with the waiver. See Waiver Attachment I.

Subpart 2. **Provider standards.** This subpart specifies that environmental modifications in the home must meet standards of the applicable state and city building codes. The subpart is necessary to

inform affected persons of a waiver requirement that must be met to receive CAC payments. See Waiver Attachment I. Compliance with state and city building codes is reasonable as these codes set standards necessary to protect the safety and well being of persons who use the structures and their appurtenances. Because the case manager is responsible to the lead agency for assuring the safety and health of the CAC recipient, it is reasonable to require the case manager to approve the provider performing the work. The case manager's approval is required by the waiver. Contracts or service agreements between the person performing the work and the entity authorizing the work establish the terms and conditions of what each party is responsible to do. Contracts and service agreements are tools for determining if the required work has been done in the requested manner. Requiring the terms of the service to be established in a contract or service agreement is reasonable because the contract or agreement helps to prevent misunderstanding, furnishes an objective measure of whether the required work was done, and provides an audit trail. It is reasonable to require the lead agency to be a party to the contract or service agreement and to assure that work is completed according to the contract or agreement as the lead agency is the local agency's designee for the administration of the recipient's CAC services.

9505.3620 MEDICAL EQUIPMENT

Subpart 1. **Eligibility for medical equipment and supplies.** The waiver authorizes the use of CAC funds to pay for medical equipment and supplies that are generally available to the individual in a hospital. See Waiver Attachment I, page 3. This subpart is necessary to inform affected persons of the availability of medical equipment and supplies through CAC. The waiver sets certain conditions for the use of CAC funds to purchase the
medical equipment and supplies. These conditions are that the equipment and supplies are specified in the recipient's plan of care, CAC is the only source available to fund the medical equipment and supplies, and the medical equipment and supplies meet the requirement of the State Plan for the "rental, purchase, and safeguarding of patient care....," as specified in part 9505.0310. This subpart is consistent with the waiver.

Subpart 2. **Prior approval required.** The waiver states that medical supplies and equipment having a value in excess of $25.00 requires "prior authorization in the patient care plan." See page 3 of Waiver Attachment I. It should be noted that prior authorization in the patient care plan is not the same as the procedure to obtain prior authorization of certain health services under parts 9505.5010 to 9505.5030 as a condition of the services' eligibility for medical assistance payment. The intent of each procedure is the same: a review to determine whether the requested service is medically necessary and appropriate. The approval also is the same, being given by the commissioner or the commissioner's designated representative. However, the procedures followed to obtain approval are not identical. One criterion of eligibility to receive CAC services is a care plan approved by the commissioner. See parts 9505.3520 and 9505.3550. This subpart is necessary to inform affected persons of a condition affecting eligibility for payment. Authorization of services specified in a CAC recipient's care plan involves as a first step the

approval of the case manager and, if appropriate, the recipient's physician and as a final step submission of the recipient's care plan to the commissioner for review as part of the commissioner's determination of the applicant's eligibility for CAC services. Criteria for obtaining the commissioner's determination that a CAC applicant is eligible for CAC services are: (1) that the cost of CAC services does not exceed the cost to medical assistance of providing inpatient hospital services for the applicant; and (2) the cost falls within the limit specified in the waiver for the aggregate annual cost of waivered services provided for all CAC recipients. See part 9505.3520, items F, G, and H. Thus it is reasonable that an item with a value greater than a minimum cost receive the commissioner's approval because submitting the information to the commissioner provides the commissioner an opportunity to determine whether the services needed by the CAC recipient meet the criteria for eligibility for payment under CAC. This subpart is consistent with the waiver requirements set forth in Waiver Attachment I, page 3.

Subpart 3. **Exemption from limitation on type of equipment and supplies available.** The waiver states that the limitations on the types or equipment or supplies available under the State Plan do not apply in the case of CAC recipients. See Waiver Attachment I, page 3. This subpart is necessary to inform affected persons. Part 9505.0310, subpart 1, item A and subpart 4, item A set the limits on the types of equipment or supplies that may be paid for using medical assistance funds. The subpart is consistent with the waiver.

9505.3622 MEDICAL TRANSPORTATION

The waiver authorizes the use of CAC funds to pay for transportation for medical purposes if the transportation exceeds the scope of or has a higher cost than set forth in the county's policy for transportation eligible for medical assistance reimbursement and is indicated in the CAC recipient's care plan or approved by the recipient's case manager. See part 9505.0140, subpart 2, which sets forth the requirement that a county must have a plan of
transportation services that assist recipients to access medical assistance services. This part is necessary to inform affected persons. It is consistent with the waiver. See Waiver Attachment I, page 3.

9505.3624 PRESCRIBED DRUGS

Subpart 1. **Eligibility for service.** The waiver authorizes the purchase of prescribed drugs as a CAC service if the prescribed drugs would be available to the recipient if the recipient were an inpatient and if the drug is authorized by the recipient's physician in the recipient's care plan. This subpart is necessary to inform affected persons of a waivered service. The subpart is consistent with the waiver. See Waiver Attachment I, page 3.

Subpart 2. **Number of prescribed drugs available to recipient.** The waiver states that recipients are eligible for prescribed drugs according to current State Plan requirements except that limtations on the number of prescriptions which may be filled or refilled shall not apply. This subpart is necessary to inform affected persons. Recipients are chronically ill individuals. By definition, they are persons whose medical condition and service needs are known and are expected to

continue over a long time. Their needs may include prescribed drugs necessary on a long term basis for maintaining them in a stable condition. Limiting the number of prescriptions which may be filled or refilled poses an additional burden on the primary caregiver or other person who is responsible for the recipient's care including obtaining and sometimes administering the prescribed drugs. Thus it is reasonable to exempt recipients from the limitations applicable to prescribed drugs under the State Medicaid Plan because removal of the limitation facilitates the recipient's care at home. State Plan requirements and limitations on medical assistance payment for prescribed drugs are found in part 9505.0340. See Waiver Attachment I, page 3in regard to Prescribed Drugs.

9505.3626. OTHER PROFESSIONAL SERVICES; THERAPY.

Subpart 1. **Eligibility for other professional services; therapies available as medical assistance services.** Health services needed by a CAC recipient to remain at home may include certain therapies that are available as medical assistance services. This subpart is necessary to clarify that a CAC recipient is eligible to receive these services while living at home. The subparts cited within subpart 1 set the medical assistance standards for the therapies provided by a physical therapist, occupational therapist, speech-language pathologist, and respiratory therapist. These services are consistent with the therapies set forth in the waiver, on page 3 of Waiver Attachment I. The waiver in Waiver Attachment I, page 3, requires that "[c]urrent safeguards and provider standards will continue to apply for all therapies covered under [CAC]....." The standards applicable to the therapies available under this subpart are set forth in parts 9500.1070 and 9505.3500 to 9505.3700. The subpart is reasonable because it informs affected persons.

Subp. 2. **Eligibility for other professional services; nutritionaltherapy.** This subpart is necessary to set inform affected persons about the availability of nutritional therapy to a CAC recipient. A CAC recipient may have specific nutritional needs that require the advice of a qualified person. A nutritionist is so qualified by experience and training. The subpart is consistent with the waiver. It is reasonable to be consistent with the waiver because the consistency is a condition to obtain federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4. See Waiver Attachment I, page 3 about nutritional therapy and Waiver Attachment II and part 9505.3510, subpart 35 about nutritionist.

Subp. 3. **Service limitations.** This subpart is necessary to set a standard of the amount, duration, and scope of therapy that may be provided to a CAC recipient. The waiver states on page 3 of Waiver Attachment I, "Limitations on the amount, duration and scope of therapies for waiver recipients will be specified in the patient care plan." This subpart is consistent with the waiver. Consistency with the waiver is reasonable because it is a condition to obtain federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4. See part 9505.3550 in regard to the CAC recipient's care plan and its approval by the recipient's physician.

9505.3630 FOSTER CARE.

Subpart 1. **Eligibility for payment.** The waiver authorizes foster care as a CAC service. It defines the service "as the provision of ongoing residential care and supportive services to enable the individual to be discharged from the hospital into other than his/her [sic] natural family unit." It specifies that "[f]oster care does not include the cost of room and board" and that funds from the Title IV-E Program and Minnesota Supplemental Aid Program are to be used to pay for room and board. See Waiver Attachment I, page 1. This subpart is necessary to inform affected persons. The definition of Title IV-E is necessary to clarify its meaning. The definition is reasonable because using the exact citation of the public law establishing the foster care program provides a reference that can easily be reviewed and removes possible misunderstandings. It also is necessary to define the term "Minnesota Supplemental Aid Program" to clarify its meaning. The definition is reasonable because using the exact citation of the state law establishing the program provides a reference that can easily be reviewed and removes possible misunderstandings.

Subpart 2. **Provider standards.** This subpart is necessary to inform affected persons of the standard required to provide foster care as a CAC service. The waiver requires that CAC service providers must meet the applicable state licensure or certification requirements. See State Medicaid Manual, section 4440, item 10 (a). Minnesota Statutes, section 245A.03 requires foster care providers to be licensed. State licensing standards of foster care of children are established in parts 9545.0010 to 9545.0260. State licensing standards of foster care of adults are established in parts 9555.5105 to 9555.6265.

9505.3635 EXCLUDED SERVICES

This part sets forth services which are not eligible to be paid as CAC services. This part is necessary to inform affected persons and avoid possible misunderstandings.

Item A is consistent with parts 9505.3580 and 9505.3630 and with the waiver. The item is necessary and reasonable because it clarifies the availability of CAC funds to pay for room and board during respite care away from the recipient's home and thus avoids possible misunderstanding in relation to the prohibition of using CAC funds to pay for room and board.

Item B is reasonable because it is consistent with Minnesota Statutes, section 256B.04, subdivision 15 which prohibits duplicate payments for the same service.

Item C. Minnesota Statutes, section 256B.04, subdivision 4 requires the state to cooperate with the federal government in any reasonable manner as may be necessary to qualify for federal financial aid in connection with the
medical assistance program. 42 CFR 433.138 and 42 CFR 433.139 require the department to use all possible sources of third party payers before using medical assistance funds to pay for a service otherwise eligible for medical assistance payment. (Also see part 9505.0015, subpart 46 which defines "third party" for purposes of the medical assistance program and part 9505.0070 in regard to third party liability under the medical assistance program.) 42 CFR 433.140 states that federal

financial participation in medical assistance payments is not available if the department has failed to fulfill requirements related to obtaining payment from third party payers. Finally, Minnesota Statutes, section 256B.37 requires a person who is otherwise eligible for medical assistance and who has private health care benefits available to use the private benefits first and to the fullest extent before supplemental payment may be made by medical assistance. Thus, this item prohibiting the use of CAC funds to pay for health services for which other funding sources are available is consistent with federal and state requirements related to obtaining third party payments.

Item D is reasonable because it clarifies that only CAC services to persons determined eligible for CAC are eligible for payment with CAC funds. This is consistent with the waiver requirements.

Item E is consistent with the waiver. See parts 9505.3550 and 9505.3622 and their SNRs.

Item F is consistent with the waiver. See Waiver Attachment I, page 2 and Model Waiver Request, Exhibit A, items 7 and 8.

9505.3640 LOCAL AGENCY RESPONSIBILITIES.

Subpart 1. **Determination of applicant's eligibility for medical assistance.** Under Minnesota Statutes, section 256B.05, the local agency (county agency) is responsible to administer medical assistance in its county. Administration of medical assistance includes the determination of eligibility to receive medical assistance under Minnesota Statutes, Chapter 256B. This subpart is necessary to clarify that the local agency is responsible for the medical assistance eligibility determination of a CAC applicant and the medical assistance eligibility redetermination of a CAC recipient. The waiver specifies that "waiver eligible clients must meet the financial and non-financial Medicaid eligibility criteria in the approved Minnesota State Plan." These criteria are found in parts 9505.0010 to 9505.0150. The waiver also states that "[u]nder that authority of section 1902(a)(10)(A)(ii)(Vl), such individuals [medically needy individuals] would be eligible for Medicaid services even if they would otherwise be ineligible for Medicaid while living at home because of the SSI deeming rules." See State Medicaid Manual, section 4440, item 3, dated 04/01/87. The result is that the income of a spouse or the income of a parent that usually is deemed available to the chronically ill individual and causes the applicant to be determined ineligible for medical assistance would not be deemed available. This subpart is consistent with the waiver. The eligibility exception that permits separation of assets of the client and a responsible parent or spouse is also reasonable because it enables the client to live in the community at less public expense than would be required in the client were ineligible for CAC and were required to be institutionalized under the medical assistance program. It is reasonable to require the eligibility determination to be made by the local agency that is or would be financially responsible for the applicant or recipient as that agency may have to use its public tax dollars to pay for the individual's services. However, it is also reasonable to
permit the local agency of the county where the applicant, recipient, or the individual, recipient resides to collect the necessary information as it is administratively efficient and, in most cases, requires the least

travel by the individual.
Subpart 2. **Designation of lead agency.** Although the local agency has the responsibility to administer medical assistance, it may choose whether
to administer CAC directly or to delegate the administration to another entity. This subpart clarifies that the local agency must decide who will administer the CAC portion of the medical assistance program within its county. Clarification is necessary to avoid misunderstanding and confusion. Permitting the local agency to designate a lead agency is reasonable because it provides the local agency the administrative flexibility that may be necessary to act in the client's best interests and furnish the client's services in a timely manner.
Subpart 3. **Calculation of parental or spousal contribution.** Minnesota Statutes, section 256B.14 specifies the responsibility of the spouse of an adult and the parent of a child to contribute partial or complete repayment of medical assistance furnished to recipients for whom they are responsible. Minnesota Statutes, section 256B.14 specifies that the department must promulgate rules to "determine the ability of responsible relatives to contribute partial or complete payment or repayment of medical assistance...." and that "the rules shall be consistent with the requirements of Minnesota Statutes, section 252.27 for parents of children whose eligibility for medical assistance was determined without deeming of the parents' resources or income." Minnesota Statutes, section 256B.14 also specifies that if, the relative failed or refused to pay, a cause of action exists against the relative for that portion of medical assistance granted after notice was given to the relative about the amount the relative was determined able to pay. This subpart is necessary to clarify the standard that is to be applied in determining the financial contribution of a CAC recipient's responsible relative. Calculating the financial contribution in the same manner as required for other the parents and spouses of other persons whose services are paid for by medical assistance is reasonable because it is consistent with the requirement that the medical assistance program be administered uniformly throughout the state.

9505.3645 LEAD AGENCY RESPONSIBILITIES
Subpart 1. **Enrollment as a CAC provider.** The lead agency may provide direct CAC services such as case management or may contract for or have a purchase agreement for such services. Thus, a lead agency is a service provider in the medical assistance program. Part 9505.0195 requires vendors who want to participate in the medical assistance program to enroll with the department as providers and specifies the standards for enrollment. This subpart clarifies the status of the lead agency. It is reasonable to require a lead agency to enroll as a provider as enrollment gives the department an opportunity to review the credentials of the lead agency and the provider agreement furnishes a means to hold the lead agency accountable for its performance. The lead agency's accountability to the department for the services it provides or for which it contracts is consistent with the waiver requirements placed on the department about safeguarding the health and welfare of the CAC recipients and assuring financial accountability for the funds expended for home and community-based services.

Subpart 2. **Compliance with rules and local agency requirements.** This subpart is necessary to clarify the lead agency's obligation to adhere to these rules, parts 9505.3500 to 9505.3700 and to the rules of the agency which made the designation. It is reasonable because adherence to parts 9505.3500 to 9505.3700 is consistent with the requirement of Minnesota Statutes, section 256B.04, subdivision 2 of implementing the medical assistance program in a uniform manner throughout the state.

Subpart 3. **Administrative functions.** This subpart specifies the administrative functions that a lead agency must perform. It identifies functions that are required either by statutes or by the waiver. The subpart is necessary and reasonable because it assures implementation in a uniform manner throughout the state, reduces the possibility of misunderstanding, and assists the department to comply with the requirements of the waiver.

Item A is reasonable because it informs lead agencies of what is required under these rules to arrange for providers of CAC services.

Item B is reasonable because it provides an opportunity to determine whether the billings are according to the CAC providers' contract, assists timely payment for CAC services through a first level review, and offers an opportunity to monitor compliance with the recipient's care plan.

Item C is reasonable because it is consistent with the requirement of Minnesota Statutes, section 256B.04, subdivision 2 that the medical assistance program be administered statewide in a uniform manner. CAC is a medical assistance program established in a waiver granted by HCFA. As a component of the medical assistance program it must comply with the requirements of the rules that are applicable to the program unless otherwise authorized under the waiver. Minnesota Statutes, section 256B.041, subdivision 1 requires the department to establish on a statewide basis a system of centralized disbursement of medical assistance payments to vendors. Part 9505.0450 establishes the standards and procedures for medical assistance provider billings to receive payment for medical assistance services. The lead agency is the enrolled provider of CAC services. Therefore, it is reasonable that the billing procedures applicable to medical assistance providers also apply to the lead agency because the requirement assures uniformity of billing procedures and is consistent with the requirement of Minnesota Statutes, section 256B.04, subdivision 2. The requirement also is consistent with the waiver provision that payments to providers of CAC services be made through the states' approved Medicaid Management Information System. See Attachment IV of Waiver.

Item D is consistent with the waiver. Consistency with the waiver is reasonable because it is a condition to obtain federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4. See Requirements and Limits Applicable to Specific Services, item 9, in Waiver Exhibit A.

Items E and F are reasonable because they provide the evidence needed by the commissioner to comply with item 10 (b) of Requirements and Limits Applicable to Specific Services, Waiver Exhibit A. Compliance with the waiver is reasonable because it is a condition to obtain federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4. They also are consistent with Minnesota

Statutes, section 256B.27.
Subpart 4. **Services to recipient.** The waiver requires the department to provide assurances that "necessary safeguards have been taken to protect the health and welfare of recipients." These safeguards include adequate standards for provider participation and compliance with all applicable state licensure and certification requirements. See Waiver Attachment, Exhibit A, Requirements and Limits Applicable to Specific Services, item 10 (a). Because the lead agency has accepted the responsibility of implementing the CAC program as the local agency's designee, it is reasonable to require the lead agency to carry out these safeguards. This subpart is necessary to inform the lead agency of actions it must take to be in compliance with the waiver.
Item A specifies a standard for the provision of CAC services. The standards are found in parts 9505.3500 to 9505.3700. The item is reasonable because it informs affected persons.
Item B limits the provision of CAC services other than respite care to times when the CAC recipient is not an inpatient. The limitation is consistent with the requirements of items 7 and 8 of Waiver Attachment, Exhibit A. Consistency with the waiver is reasonable because it is a condition to obtain federal financial participation as required by Minnesota Statutes, section 256B.04, subdivision 4.
Item C is reasonable as it provides the commissioner the evidence needed to comply with items 6 and 10 of Waiver Attachment, Exhibit A. Compliance with the waiver is a condition to obtain federal financial participation as required by Minnesota Statutes, section 256B.04, subdivision 4.

9505.3650 **PROVIDERS OF CAC SERVICES.**
Subpart 1. **Criteria for selecting a CAC provider.** This subpart specifies the criteria for selecting a CAC provider of home and community-based services. Criteria are necessary in order to establish a standard and assure that selection is objective.

Item A requires a CAC provider to be an employee of the county or have a contract or purchase or service agreement with the lead agency. As stated in the SNR of part 9505.3645, subpart 3, item A, the lead agency is an enrolled provider in the medical assistance program. As such, the lead agency is responsible for arranging for the services. A contract or agreement is a reasonable way to arrange for a service because a contract or agreement specifies the terms applicable to the seller and the purchaser, reduces the possibility of misunderstanding, and provides an audit trail. See subpart 2 which sets forth the terms and conditions applicable to contracts and agreements between the lead agency and the CAC service provider. Although the lead agency has been designated by the county (local agency) to implement the county's CAC program, the county itself is directly responsible to the department for the CAC program. A county may choose to provide some CAC services through members of its own staff. An example is case management services provided by a county-employed social worker. A person employed by a county must meet qualifications established by the county board for the position and is supervised to ensure the person's work meets the requirements of the position. Thus it is reasonable to provide as an alternative to a contract or agreement for services that a person

employed by the county may be a CAC provider because county employment assures the person meets at least a minimum standard of qualification for and performance in the assigned service.

Item B is consistent with the waiver which requires that individuals furnishing services provided under the waiver must take necessary safeguards to protect the health and welfare of recipients, including meeting all state licensure or certification requirements for the recipients' services they provide. Consistency with the waiver is reasonable because it is a condition to obtain federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4. See item 10 (a) of Waiver Attachment, Exhibit A.
Item C is necessary to ensure that primary caregivers who have agreed to perform for the recipient essential services without reimbursement do not in fact receive payment from the program. The item is reasonable because it enables relatives to comply with statutory requirements for responsibility and ensures the integrity of the CAC program which is centered around the informal and non-reimbursed services of a primary caregiver.
Subpart 2. **Agreement to provide CAC services.** A purchase agreement, service agreement, and contract are customary business instruments drawn up between a purchaser and a service provider. This subpart specifies the contents of such instruments entered into by the lead agency and a CAC service provider. This subpart is necessary to establish a standard.

Items A, B, C, E, and I are customary terms of business agreements and contracts. Item D is reasonable as it is consistent with the waiver requirement that the amount, frequency, and scope of a CAC service is to be specified in the recipient's care plan. Item F is consistent with the waiver requirement that the state must assure an audit trail of funds expended under the waiver and include a description of the records and information that will be maintained to assure financial accountability and must make these records available to the federal government. Items G and H are reasonable because they inform CAC service providers of state requirements and mandate compliance.

9505.3660 CAC PROVIDER RECORDS
The waiver requires the department to maintain and make available to the federal government appropriate financial records documenting the cost of services provided under the waiver. See Model Waiver Request Attachment A, item 10 (b). The waiver also requires the department annually to provide HCFA with information on the impact of the waiver on the type, amount, and cost of services provided under the State plan and on the health and welfare of the recipients. See Model Waiver Request Attachment A, item 10 (g). This part specifies the records CAC providers must keep about the services provided, the clients served, and the cost of the services. This part is necessary to establish a uniform standard through-out the state as required by Minnesota Statutes, section 256B.04, subdivision 2. Parts 9505.1750 to 9505.2150 set the standards for recordkeeping in regard to surveillance and utilization review in the medical assistance program as required under Minnesota Statutes, section 256B.04, subdivision 15. CAC is a medical assistance program. It is reasonable to use these standards to meet the recordkeeping requirements

of the waiver because their use coordinates recordkeeping under medical assistance and thereby avoids possible confusion about which standards apply to which part of the medical assistance program. See Waiver Exhibit A, item 10 (b) and (g).

9505.3670 RATES FOR CAC SERVICES

Subpart 1. **Maximum CAC service rate.** This subpart is necessary to set maximum service rates under CAC. CAC is one of several medical assistance programs offering alternative care to Minnesota residents who are medical assistance recipients and at risk of institutionalization. These programs have been authorized under waivers from the federal government. The authorizing waivers do not set the rates for the waivered services. However, the department submitted cost data in its request to renew the CAC waiver which were the bases for the estimated total annual program expenditure and the average annual expenditure per individual. In renewing the waiver in 1988, HCFA approved these estimates of the total annual program expenditure and the average annual expenditure per individual and thereby imposed them as the limit required under the terms of the waiver. See letter dated March 22, 1988 from William Roper and the average cost worksheet attached to letter dated February 25, 1988 from Catherine Griffin.

The cost data discussed above were derived from the average cost per unit of service to the Minnesota medical assistance population and the total number of units of each service. Home and community-based services under a

waiver are similar in nature regardless of the population being served. For example, services include homemaker, respite care, case management, nursing, and home health aide services. Thus it is reasonable to permit the commissioner to set maximum payment rates for the same or similar services provided by the same or similar providers to a similar population, persons who are instituionalized or at risk of institutionalization. It also is reasonable to require the commissioner to set maximum payment rates in order to assure that comparable services are available at comparable rates and thereby provide equity for providers of comparable services. Furthermore, the waiver requires the department to control the expenditures for home and community-based services provided to individuals under the waiver. The authority to set maximum CAC service rates is necessary to comply with the requirement of Minnesota Statutes, section 256.01, subdivision 2(11), which directs the commissioner to set statewide maximum charges to be paid. Minnesota Statutes, section 256B.4, subd. 2, directs the commissioner to uniformly administer the welfare programs in an efficient and economical manner. The commissioner's responsibility to control the service expenditures and to maximize the use of available funds.

It should be noted that the medical assistance payment rates are set pursuant to part 9505.0445 and that payment rates for waiver services for persons who are at least 65 years old and nursing home residents or at risk of nursing home admission are set by the commissioner pursuant to part 9505.2490 and Minnesota Statutes, section 256B.091, subdivision 8. Thus, the commissioner's ability to set CAC rates is consistent with other rate setting authority exercised by the commissioner. Basing rates on comparable services offered through other assistance programs is

reasonable because it complies with Minnesota Statutes, 256B.04, subdivision 2, which requires the department to make consistent rules for the uniform administration of medical assistance. Economic circumstances beyond the control of the state, county, or provider may vary from year to year in ways that affect the costs of providing services. It is reasonable to require the commissioner to make an annual adjustment of the maximum CAC service rate in order to reflect the effect of cost increases beyond the provider's control. Basing the increase on the cost changes occurring from one year to the following year is reasonable because it ensures implementation of the CAC program in an economical and equitable manner. The index used to update the rates is the change in the Home Health Agency Market Basket between the two most recent Aprils before the rate year. Using the Home Health Agency Market Basket is reasonable because it reflects cost changes in the market basket of goods and services of health care agencies. The Home Health Agency Market Basket is in common usage to adjust prices to be congruent with cost changes. The Home Health Agency Market Basket is used in determining other rates set by the Department. It is published quarterly. Using the Home Health Agency Market Basket is reasonable because this index reflects the market basket item costs in Minnesota and provides the commissioner the opportunity to adjust the rate in a manner that will recognize the changing costs inherent in services in Minnesota. Specifying the date on which a rate increase is authorized is necessary to set a standard and ensure uniform administration of the CAC program as required under Minnesota Statutes, section 256B.04, subdivision 2. July 1 is the beginning of a state fiscal year. Adjusting rates to coincide with the beginning of the state's fiscal year is reasonable because fiscal resources for the coming year are made available at that time. Finally it is necessary and reasonable to state that the commissioner's ability to set and adjust maximum rates under this subpart may be limited by
legislative action because the information is necessary to inform affected persons.

Subpart 2. **Notice to counties.** Under subpart 1, the commissioner annually sets maximum rates for CAC services on a statewide basis. Lead agencies need to know these rates to prepare their county plans and budgets. This part is necessary to establish who shall notify the lead agencies and when the notice is to be made. It is reasonable to require the commissioner to notify the lead agencies because the rates are established by the commissioner. Annual notice is a reasonable requirement because the rates are adjusted annually according to subparts 1 and 3. Finally the date of June 1 is reasonable because it is consistent with the time when the April data become available.

Subp. 3. **County CAC service rate.** Services reimbursed through the medical assistance program are subject to review under Minnesota Statutes, section 256B.04, subdivision 15 which requires the state agency to safeguard against excess payments. Payments must be necessary and reasonable, based on sound business practices that are reasonably related to the cost of delivering the service which is billed. Requiring an audit for a lead agency CAC service rate is necessary because the commissioner has the responsibility to ensure that the rates are not exceeded. Thus, this subpart is consistent with the cited statute and is

reasonable. It is also necessary and reasonable that the commissioner is able to recover any money paid by the department that is in excess of the established rates or that is excess of the actual cost of delivering the billed service.

9505.3680 **DEPARTMENT RESPONSIBILITIES**

Subpart 1. **Review and approval of CAC applications.** This subpart establishes the department's responsibility of determining an applicant's eligibility for home and community-based services under CAC and giving notice of the decision. The subpart is necessary to clarify the responsibilities. The waiver requires the commissioner to determine an applicant's eligibility for CAC. See Model Waiver Request Attachment A, items 6, 9, and 10 (c) and (d). It is reasonable to require the commissioner to notify the applicant's acting case manager and the lead agency of the decision because the acting case manager and the lead agency are responsible for case management services for the applicant and need to know the applicant's status in order to carry out their responsibilities. The department's experience in processing applications indicates that 15 working days is sufficient time in which to review the application from a chronically ill individual who has a complexity of service needs, make a decision about approving the application or needing additional information, and send a notice to the applicant's case manager. Chronically ill persons at risk of or requiring frequent hospitalization may have extensive and critical needs for health services. It may be difficult to determine if the documents fully and correctly describe the applicant's condition so that the CAC provider can meet the applicant's needs. It may be difficult to locate and contract for properly qualified providers. Therefore, the department believes it would be unreasonable to require the review to be completed and notices to be sent in less than 15 working days as such a time limit might work against the best interests of the applicant and the department's responsibility to protect the health and welfare of the recipients. The 15 working day requirement is also reasonable in that it balances the department's need to verify application information with the applicants need for services.

Subpart 2. **Review of care plan and eligibility reassessments.** Part 9505.3545 requires periodic review and revision of a recipient's care plan. It also requires the revised plan and other reassessment documents to be submitted to the commissioner for a determination of whether the recipient continues to be eligible for CAC. This subpart specifies the commissioner's responsibility for determining whether a CAC recipient continues to be eligible for CAC. The subpart is necessary to clarify the commissioner's responsibility. It is consistent with the waiver. See Model Waiver Request Attachment A, items 6 and 10 (c). The rule is reasonable because it is based on criteria specified in part 9505.3520, which is consistent with the waiver. The rule sets a time limit for the commissioner's decision to approve or deny the recipient's continued eligibility and revised care plan. It is therefore reasonable for the department to maintain its flexibility by performing reviews when time and personnel permit, while at the same time maintaining the status quo for a recipient who is already receiving CAC services. Under the proposed rule, the recipient will not be prejudiced by any delay in the

department's review process, but rather would continue to receive necessary services, pending the outcome a redetermination of eligibililty.

Subpart 3. **Records.** This subpart specifies the department's responsibility to maintain records related to the community alternative care program. It is necessary to set a standard. The waiver requires the department to keep records but does not specify the length of time to retain the records. See Model Waiver Request Attachment A, items 10 (b), (c), and (g). The requirement of five years is consistent with the record retention provision in part 9505.1850 which sets a medical assistance standard for the surveillance and utilization review program pursuant to Minnesota Statutes, section 256B.04, subdivision 15. Using the same standard applied to other medical assistance programs is reasonable because it avoids confusion on the part of administering agencies and is administratively efficient.

Subpart 4. **Monitor program expenses.** This subpart is necessary to inform all affected persons of a waiver requirement that expenditures for CAC services remain within certain limits. These limits which specify both the number of individuals to be served and the costs of services are conditions that the department must meet to receive federal financial participation in paying the costs of CAC services. See letter of William L. Roper, HCFA, to Maria R. Gomez, Assistant Commissioner, Department of Human Services, date-stamped as received by the Department March 25, 1988 in which Dr. Roper notifed the Department that HCFA approved the renewal of the waiver; see February 25, 1988 letter and attachments from Maria Gomez to Verna Tyler, HCFA. See also Model Waiver Request Attachment A, items 8, 9, and 10 (e). Consistency with the waiver is reasonable because it is a condition to obtain federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4.

9505.3690 BILLING FOR CAC SERVICES

This part clarifies the procedure that affected persons must follow in order to receive payment for CAC services. It is reasonable to require CAC providers to submit claims as directed by the commissioner as the commissioner, as specified in the waiver, must assure HCFA that the cost of services specified in the care plan does not exceed the approved estimated cost of the plan. Carrying out this responsibility reasonably requires the commissioner to establish, and to modify when necessary, a systematic approach to billing for and tabulating the costs of CAC services. The proposed rule provides the commissioner the means to implement the
methodology most likely to enable her compliance with the waiver obligation. Part 9505.0450 establishes billing procedures applicable to medical assistance services provided under parts 9505.0170 to 9505.0475. It is reasonable to require the same standard because a single standard avoids confusion, provides comparable records about medical assistance services that are available to the department in evaluating the costs of medical assistance programs including CAC, and is administratively efficient

9505.3700 APPEALS.

This part covers the general provisions for appeals by CAC recipients.

Federal regulations, 42 CFR 431.200 to 431.250, require an appeal process for recipients. CAC services are funded by medical assistance under the waiver and are considered public assistance services under Minnesota Statutes, section 256.045, subdivision 3. Minnesota Statutes, section 256.045 establishes the right of a person whose application for services under Minnesota Statutes, chapter 256B, is denied or whose assistance is suspended, reduced, or terminated to contest that decision. Minnesota Statutes, section 256.045 also establishes the time limitations for submitting a written request for a hearing, the conduct of the hearing, who shall hear the appeal and who shall issue an order on the matter, and the right of a party aggrieved by the order to seek judicial review.

Subpart 1. **Appealable actions.** Items A, B, and C permit a medical assistance recipient and applicant to appeal from a local agency's medical assistance eligibility decision or the department's decision about the person's eligibility for home and community-based services. It is necessary to notify parties of appealable actions. Minnesota Statutes, section 256.045 specifies that a person may appeal actions affecting the person's request for or continuation of medical assistance services. It is reasonable to permit a similar appeal of actions affecting waivered services to medical assistance recipients who are also CAC applicants or recipients in order to assure consistency in administration of the medical assistance programs as required by Minnesota Statutes, section 256B.04, subdivision 2.

Subpart 2. **Actions that are not appealable.** There is no entitlement to CAC services. Eligibility for CAC services is limited by the waiver. The waiver specifies that medical assistance cost of home care cannot exceed the medical assistance cost of hospital care. See Model Waiver Request Attachment A, item 9. It also specifies the number of openings available for each year of the program. See letter from William L. Roper, HCFA, to Maria Gomez received in the department March 25, 1988. Because these conditions must be followed to receive federal financial participation in the costs of the services, it is reasonable to list them as unappealable issues. The case manager may determine that it is necessary to withdraw services to protect the health and safety of a recipient. It is necessary and reasonable to deny the right to appeal a withdrawal resulting from an action necessary to assure the health or safety of the CAC recipient because this denial is consistent with the need to safeguard the recipient's health and safety and is based on recommendations of qualified professionals. See Model Waiver Request, Exhibit A, item 10 (a).

Subpart 3. **Notice of right to appeal.** Informing an applicant about appeal rights is necessary to assure that he or she is aware of rights available under Minnesota Statutes, section 256.045. It is reasonable to require the case manager to inform an applicant or recipient whoseeligibility or continuing eligibility is being assessed of appeal rights because the case manager has direct contact with him or her during the process. Requiring written material including a Notice of Action to be given is reasonable because it is evidence that the information was given and minimizes misunderstanding about the action and the CAC recipient's right to appeal. It should be noted that a denial of CAC service may originate from anyone of three sources: the department, the case manager, or the lead agency. The CAC recipient has the right to

appeal regardless of the source of the denial.
Subpart 4. **Submission of appeals.** Minnesota Statutes, section 256.045, subdivision 3, establishes the procedure for making an appeal concerning public assistance programs. This subpart is consistent with the cited statute. Including this information in the rule is necessary and reasonable because it informs affected persons.
Subpart 5. **Appeal of action.** This subpart is necessary to put parties on notice that an appeal under this part will be heard as required by the cited statute. It is reasonable because the statute governs all appeals of medical assistance programs.
Subpart 6. **Continuation of services pending an appeal.** This subpart clarifies that a CAC recipient who appeals a termination, suspension, or reduction of CAC services will continue to receive the CAC services pending the decision on the appeal. This requirement is reasonable because the CAC recipient will continue to receive health care services and will be able to continue to live at home. The requirement also is reasonable as it benefits the chronically ill recipient.

Expert Witnesses

If this rule should be heard in public hearing, the Department does not plan to have outside expert witnesses testify in its behalf.

Date: 7-31-90 1990

ANN WYNIA
COMMISSIONER OF HUMAN SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES

Attachment A

Current waivers — (began 4/1/88)

RECEIVED
'88 AUG 22 PM 1:37
MAR 22 1988
ADMINISTRATIVE HEARINGS

The Administrator
Washington, D.C. 20201

Ms. Maria R. Gomez
Assistant Commissioner
State of Minnesota
Department of Human Services
Human Services Building
444 Lafayette Road
St. Paul, Minnesota 55155-3844





Dear Ms. Gomez:

I am pleased to inform you that the revised request for renewal of your Medicaid model waiver (control number 40128.90) to provide home and community-based services to eligible Medicaid recipients, as authorized under the provisions of section 1915(c) of the Social Security Act, has been approved.

You submitted a request to continue to provide the following services to chronically ill individuals who are technology dependent and/or require significant amounts of nursing services on a daily basis: case management, respite care, environmental modifications to the home, family counseling, family training, homemaker, foster care, nursing, home health aide, physical therapy, occupational therapy, speech therapy, nutritional therapy, respiratory therapy, physician, prescribed drugs, supplies/equipment and transportation. You also requested continuation of the waiver of the "amount, duration and scope of services" requirement set forth in section 1902(a)(10(B) of the Social Security Act.

Based on the assurances and information you provided, I approve the revised model waiver renewal request cited above for a 5-year period effective April 1, 1988. Please note that this approval is subject to the State's agreement to complete an independent assessment of the waiver at least 90 days prior to the expiration of the approved renewal which will cover the first 48 months of the waiver. This approval is also subject to your agreement to provide home and community-based services to no more individuals than those indicated in the estimate of Factor C in your approved per capita expenditure estimates (shown below). The values shown for Factor C include the State's estimates that 16 persons will be replaced during the waiver due to death or loss of eligibility for Medicaid services. The following are estimates for each year: 2 in waiver year 1; 3 in waiver year 2; 3 in waiver year 3; 4 in waiver year 4; and 4 in waiver year 5.

The following estimates of utilization and cost of waiver services have been approved for the renewal:

	C	x	D	Total
Year 1 (April 1, 1988 to March 31, 1989)	52	x	$186,145	= $ 9,679,540
Year 2 (April 1, 1989 to March 31, 1990)	65	x	$199,766	= $12,984,790
Year 3 (April 1, 1990 to March 31, 1991)	77	x	$203,579	= $15,675,583
Year 4 (April 1, 1991 to March 31, 1992)	90	x	$206,177	= $18,555,930
Year 5 (April 1, 1992 to March 31, 1993)	102	x	$209,861	= $21,405,822

The waiver renewal request, as revised, conforms fully to the requirements of the statute and Medicaid regulations. We appreciate the effort and cooperation provided by you and your staff.

Sincerely,

William L. Roper

William L. Roper, M.D.
Administrator

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
Human Services Building
444 Lafayette Road
St. Paul, Minnesota 55155-38___

COPY

December 30, 1987

William L. Roper, Administrator
Health Care Financing Administration
Bureau of Eligibility, Reimbursement
and Coverage
100 East High Rise
6325 Security Blvd.
Baltimore, MD 21207

Dear Mr. Roper:

On May 13, 1985, Minnesota received approval for a Home and Community Based Model Waiver (#40128) to provide case management, respite care, environmental modifications to the home, homemaker, family counseling and training and foster care services to categorically, optional categorically and medically needy chronically ill children under 21 years of age who would otherwise reside in acute care hospitals. An amendment was submitted, and approved, to extend coverage to chronically ill individuals under 65 years of age.

Authorization for Minnesota's Model Waiver ends after March 31, 1988. Therefore, per the State Medicaid Transmittal No. 29, from July 1987, Minnesota is requesting a five year extension of the existing waiver.

Minnesota assures that all the assurances and information provided in the approved waiver as required by 42 CFR 441.302(a)-(f) remain in effect, including any amendments approved by HCFA.

The services described in the original waiver request remain the same. No new services or changes to existing services, are requested with the waiver extension. The target population remains the same as the approved waiver and any amendments which were approved by HCFA.

All of the eligibility requirements and procedures described in the original waiver and any amendments approved by HCFA will remain in effect under the extended waiver. In addition, all of the safeguards to protect the health and welfare of waiver recipients as described in the original waiver will stay the same.

Enclosed you will find Minnesota's per capita expenditure estimates, as described at 42 CFR 441.303(f), for each year of the extended waiver. In addition, we are submitting data on the estimated cost of the individual home and community based services to support the cost data contained in the formulas.

The Department, as well as medical providers, counties and families of chronically ill individuals, has been very pleased with the success of the Community Alternative (CAC) Program. We look forward to working together with HCFA during the extension process. If you, or your staff, have any questions, please feel free to contact Catherine Griffin, of my staff, at (612) 296-2917.

Thank you for your assistance.

Sincerely,

Maria R Gomez

Maria R. Gomez
Assistant Commissioner

MRG/lmw

Enclosures

cc: Vytas Zalatorius
Trish MacTaggart

Explanation of Methodologies

1. The CAC Program is available only to individuals who would otherwise reside in, or be at risk of, an acute care hospital. Most of these individuals are dependent on some form of technology to sustain their life and/or require significant amounts of nursing services on a daily basis. In order to not be limited to a "conversion only" waiver, we have used our actual hospital costs for our entire Medicaid (MA) population as reported on our draft 2082 for FY 1986.

   Although the FY 1986 3082 is only in draft form (it is near completion), we used it because we believe the information is more accurate than on previous reports. This is because in prior years, recipients were counted by MA ID numbers. Thus, it was very likely that an individual could have been assigned more than one MA ID number during the course of a year and thereby was counted twice (or more) in the report. We now are reporting recipients by social security number and we assume we are reducing our chances of counting individuals more than once. Therefore, we should have a much more accurate unduplicated count.

2. All costs and numbers are based on unduplicated counts. Information on numbers and costs were derived from: a) Minnesota's 372's for existing waivers, b) Minnesota's 2082 which is being prepared for FY 86, and c) actual CAC case information.

   Any costs used from previous years reports have been adjusted for the amount of time which has elapsed from the date of the report to the beginning of the CAC waiver year which would be 4/1/88. All corresponding adjustments from waiver year to waiver year are computed on an annual basis.

   The inflation factor used in G and G' was taken from the Health Care Costs National Forecast with and adjustment factor of six months (difference between the federal fiscal year and the CAC waiver year).

3. The number of individuals who will be served by the CAC Program have been determined based on our current program activity. In the past several months, we have had an increased amount of application activity. We anticipate that the waiver will have a slow but steady growth over the next five years due to the growing number of individuals who rely on technology to sustain their lives. We estimate that we will serve approximately fifteen new individuals each waiver year. We also anticipate that some individuals will lose their waiver eligibility each year. We anticipate that the following numbers of individuals will lose their eligibility due to death or loss of MA eligibility under the State Plan:

Waiver Year 1	5
Waiver Year 2	6
Waiver Year 3	7
Waiver Year 4	9
Waiver Year 5	10

4. The G factor is based on Minnesota's hospital cost to MA information which was taken from _____ and adjusted for the CAC waiver year. The figure in G is larger than the figure in B because of the great cost to MA to maintain CAC individuals in hospitals. Currently, in Minnesota, hospital costs are paid on a DRG system. Because CAC eligible individuals become day outliers, Minnesota would pay a daily per diem for all CAC eligible individuals. The per diems vary by diagnosis and hospital as well as between adults and children.

   The figure in G includes the outlier costs for the 50 individuals who would receive long term hospital care without a waiver. The figures used are based on actual costs for 21 cases which are currently receiving waivered services under CAC. The annual cost of inpatient hospital services ranges from $59,640 to $500,050. The average cost for inpatient hospital services for these individuals is $296,257.16. Because these figures were used when computing G, it is impossible for B and G to be the same.

5. A does not equal A'. This was much to our disbelief. However, according to our FY 86 2082 information, we are only reimbursing a physician charge for about one out of every three hospital stays.

6. All of the figures used in the formulas have been rounded to the nearest whole dollar.

7. The only acute care services listed in B' and G' are physician services.

8. Savings for each year of the waiver are based on the months of home care versus the months of hospital care. Each waiver year begins with a base of individuals already receiving services to which the individuals who will begin to receive waivered services in that year are added. In year one we will begin with a base of thirty individuals who would otherwise be hospitalized a full 12 months. We will add 20 individuals who will each receive an average of 6 months of waivered services. Each additional year begins with a base which is modified for a 10% turnover rate (see #3). For years 2-5 we have used an average of 7.33 months for individuals who are added to the waiver.

9. We have used zero values for H x I because individuals who require the level of care to be eligible for this waiver will not be safely or adequately discharged under Minnesota's State Plan. One of the key services which is missing under our State Plan is case management.

If you have any questions about the formula computations, please call:

Don Richardson	(612) 296-2465; or
Phyllis Zwieg	(612) 296-2916; or
Catherine Griffin	(612) 296-2917

cc: Vytas Zalatorius
Trish MacTaggart

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
Human Services Building
444 Lafayette Road
St. Paul, Minnesota 55155-3844

February 25, 1988

Verna Tyler
Health Care Financing Administration
Bureau of Eligibility Reimbursement and Coverage
100 E. High Rise
6325 Security Blvd.
Baltimore, MD 21207

Dear Ms. Tyler:

Thank you for an opportunity to provide clarification and corrections to Minnesota's request to extend its Home and Community Based Model Waiver for Chronically Ill Individuals (#40128). This letter replaces the letter of February 17, 1988.

Minnesota assures HCFA that all of the procedures, standards and assurances which are contained in the waiver application which was approved effective April 1, 1985, will remain in effect. In addition, all procedures, standards and assurances which are contained in the amendments which were approved by HCFA will also remain in effect and waivered services will only be provided when necessary to avoid institutionalization. Minnesota also assures HCFA that out of home respite care will be limited to no more than 720 hours.

The third paragraph of our letter dated December 30, 1987 contained an incorrect cite. Minnesota assures HCFA that we will comply with all of the regulations found in 42 CFR 441.301 (a to b), 443.302 (a to f) and 42 CFR 441.303 (a to c). Minnesota will provide an independent assessment of the waiver. However, because we assume that if the renewal is approved it will be for a five year period we would anticipate a need to change the time frame. The results of the assessment will be submitted at least 90 days prior to the expiration of the approved renewal and will cover the first forty eight (48) months of the waiver.

Enclosed you will find corrections and adjustments made to the formula per our discussion as well as accompanying explanations as to how the numbers were derived. Thank you for your assistance helping us with these technical oversights. Please call me if you have additional concerns at (612) 296-2917.

MN 1

Sincerely,

Catherine Griffin

Catherine Griffin
Long Term Care Management Division

CG/lmw

Enclosures

cc: Vytas Zalatorius
Trish MacTaggart

WORKSHEET FOR EQUATIONS SUBMITTED WITH WAIVERED SERVICES PROPOSALS

FORMULA LABEL	VALUES FOR CAC PROGRAM YEAR ONE	YEAR TWO	YEAR THREE	YEAR FOUR	YEAR FIVE
A	55,295	58,289	61,445	64,772	68,279
A'	18,113	19,094	20,128	21,217	22,366
B	$ 3,586	$ 3,782	$ 3,996	$ 4,227	$ 4,471
B'	$ 52	$ 55	$ 58	$ 61	$ 65
C	52	65	77	90	102
C'	52	65	77	90	102
D	$ 186,145	$ 199,766	$ 203,579	$ 206,177	$ 209,861
D'	$ 47,345	$ 50,809	$ 51,779	$ 52,440	$ 53,377
F	55,339	58,346	61,514	64,854	68,373
F'	18,127	19,112	20,150	21,244	22,397
G	$ 3,819	$ 4,085	$ 4,362	$ 4,658	$ 4,968
G'	$ 55	$ 59	$ 63	$ 68	$ 72
H	0	0	0	0	0
I	$ 0	$ 0	$ 0	$ 0	$ 0

TOTALS:

WAIVER	$ 3,820	$ 4,075	$ 4,330	$ 4,601	$ 4,879
NO WVR	$ 3,837	$ 4,104	$ 4,383	$ 4,680	$ 4,992

YEAR ONE
198287870 + 941876 + 9679540 + 2461940 + 0 / 55339 =
211371226 / 55339 =
3819.57
211339641 + 996985 + 0 / 55339 =
212336626 / 55339 =
3837.02

YEAR TWO
220448998 + 1050170 + 12984790 + 3302585 + 0 / 58346 =
237786543 / 58346 =
4075.46
238343410 + 1127608 + 0 / 58346 =
239471018 / 58346 =
4104.33

YEAR THREE
245534220 + 1167424 + 15675583 + 3986983 + 0 / 61514 =
266364210 / 61514 =
4330.14
268324068 + 1269450 + 0 / 61514 =
269593518 / 61514 =
4382.64

YEAR FOUR
273791244 + 1294237 + 18555930 + 4719600 + 0 / 64854 =
298361011 / 64854 =
4600.50
302089932 + 1444592 + 0 / 64854 =
303534524 / 64854 =
4680.27

YEAR FIVE
305275409 + 1453790 + 21405822 + 5444454 + 0 / 68373 =
333579475 / 68373 =
4878.82
339677064 + 1612584 + 0 / 68373 =
341289648 / 68373 =
4991.59

A

AVERAGE COST WORKSHEET for Estimated WY-88 Date-of-Service Data

KNOWN COSTS OR ESTIMATES FROM CURRENT RECIPIENTS OF WAIVERED SERVICES	INPATIENT COSTS	INPATIENT COSTS	INPATIENT COSTS
	$458,805.00	$281,309.00	
	336,648.00	237,250.00	
	174,470.00	400,200.00	
	356,240.00	268,164.00	
	155,855.00	276,816.00	
	252,000.00	238,872.00	
	255,500.00	429,696.00	
	59,640.00	443,292.00	
	299,300.00	253,675.00	
	331,343.00		
	500,050.00		
	212,288.00		
TOTAL COSTS		$6,221,413	
COST/PERSON		$296,257.76	

****

"F" (FFY86 DRAFT)	49071		
(85 rpt)/(84 rpt)	52423/49730		
Annualized Factor	1.05415		
"F" (87 estimate)	51064		
"F" (WY-88 est.)	52447		
	INP "F-1"	INP "F-2"	"F-2" Deinst.
"F" (WY-89=Year 1)	55287	52	8
"F" (WY-90=Year 2)	58281	65	8
"F" (WY-91=Year 3)	61437	77	8
"F" (WY-92=Year 4)	64764	90	8
"F" (WY-93=Year 5)	68271	102	8

"G" (FFY86 DRAFT)	$3,190.31	=	$156,551,527 / 49,071	
Adjustment Factor	1.06181 (using FFY86 Costs to Estimate WY-88)			
"G" (WY-88 est.)	$3,387.49	(6.2%)	$296,257.76	
	(G-1) = ("B")		(G-2)	
"G" (WY-89=Year 1)	$3,563.64	(5.2%)	$311,663.16	(5.2%)
"G" (WY-90=Year 2)	$3,759.64	(5.5%)	$328,804.63	(5.5%)
"G" (WY-91=Year 3)	$3,973.94	(5.7%)	$347,546.49	(5.7%)
"G" (WY-92=Year 4)	$4,204.43	(5.8%)	$367,704.19	(5.8%)
"G" (WY-93=Year 5)				

[illegible] are the [illegible]

FFY86: 2082 Draft 17,180 Visits $794,969 Costs

"G'" (FFY86 Draft) $46.27 (assuming one visit per patient)

"B'/B"="G'/G" (86) 0.01450 (Use for Succeeding Years)

"A'/A"="F'/F" (86) 0.32757 (Use for Succeeding Years)

"D'" (WY-87 rprt) $12,034.00 (WAIVER RECIPIENTS)

"D" (WY-87 rprt) $47,314.00 (WAIVER RECIPIENTS)

"D'/D" Factor (87) 0.25434 (Use for Succeeding Years)

==========

Due to the population being considered:

"H" (All Years) = 0

"I" (All Years) = $0.00

WAIVER RECIPIENT SUMMARY TABLE

	RECIPIENTS AT START OF YEAR	ACCESSIONS TO WAIVER	TURN-OVER (LOSSES)	RECIP. COUNT E-O-Y	UNDUP COUNT
Year One	35	17	3	49	52
Year Two	49	16	5	60	65
Year Three	60	17	6	71	77
Year Four	71	19	7	83	90
Year Five	83	19	8	94	102

WAIVER ELIGIBILITY	(MONTHS OF CARE)	(AVG TIME ON WAIVER)
Year One	504	9.69 Mos.
Year Two	654	10.06 Mos.
Year Three	786	10.21 Mos.
Year Four	924	10.27 Mos.
Year Five	1062	10.41 Mos.

For these computations, recipients who "turn over" or "access" during the year are assumed to receive an average of six months of service.

The formulas are as follows:

Months of Care: ([(RECIP AT START) less (TURN-OVER)] times [12]) plus ([(ACCESSIONS) plus (TURN-OVER)] times [6])

Avg Time on Waiver: (MONTHS OF CARE) divided by (UNDUPL. COUNT)

C

Home and Community Care Services for CAC

Year One SERVICE	Number of Individuals	Average Units of Service/Individual	Average Cost per Unit	Total Cost/Year
Case Management	52	1,179 (15 min.)	$ 15.25	$ 934,947
Respite Care	14	24 (1 day)	261.00	87,696
Modifications	17	1 (once/year)	1000.00	17,000
Family Counseling	7	32 (15 min.)	15.00	3,360
Family Training	41	32 (15 min.)	6.25	8,200
Homemaker	22	840 (1 hour)	8.00	147,840
Foster Care	10	242 (1 day)	20.00	48,400
Extended MA Services:				
Nursing	47	5,307 (1 hour)	22.50	5,612,153
Home Health Aide	10	3,538 (30 min.)	4.50	159,210
Physical Therapy	39	624 (15 min.)	11.00	267,696
Occupational Therapy	39	624 (15 min.)	12.00	292,032
Speech Therapy	26	624 (15 min.)	11.25	182,520
Nutritional Therapy	12	48 (15 min.)	5.75	3,312
Respiratory Therapy	27	1,248 (15 min.)	8.75	294,840
Physician	52	24 (visit)	81.00	101,088
Prescribed Drugs	23	36 (item)	10.00	8,280
Supplies/Equipment	52	240 (item)	121.00	1,510,080
Transportation	6	10 (1 trip)	15.00	900
GRAND TOTAL				$9,679,554

Total Estimated Expenditures	$9,679,554
Individuals Served	52
Average per Individual	$186,145

D

Year Two SERVICE	Number of Individuals	Average Units of Service/Individual	Average Cost per Unit	Total Cost/Year
Case Management	65	1,280 (15 min.)	$ 15.56	$ 1,294,592
Respite Care	18	26 (1 day)	266.22	124,591
Modifications	21	1 (once/year)	1000.00	21,000
Family Counseling	9	35 (15 min.)	15.30	4,820
Family Training	51	35 (15 min.)	6.38	11,388
Homemaker	28	912 (1 hour)	8.16	208,374
Foster Care	13	263 (1 day)	20.40	69,748
Extended MA Services:				
Nursing	59	5,761 (1 hour)	22.50	7,647,728
Home Health Aide	13	3,841 (30 min.)	4.59	229,192
Physical Therapy	49	624 (15 min.)	11.00	336,336
Occupational Therapy	49	624 (15 min.)	12.00	366,912
Speech Therapy	33	624 (15 min.)	11.25	231,660
Nutritional Therapy	15	48 (15 min.)	5.75	4,140
Respiratory Therapy	34	1,248 (15 min.)	8.75	371,280
Physician	65	24 (visit)	81.00	126,360
Prescribed Drugs	29	36 (item)	10.00	10,440
Supplies/Equipment	65	240 (item)	123.42	1,925,352
Transportation	6	10 (1 trip)	15.00	900
GRAND TOTAL				$12,984,812

Total Estimated Expenditures	$12,984,812
Individuals Served	65
Average per Individual	$199,766

E

Year Three SERVICE	Number of Individuals	Average Units of Service/Individual	Average Cost per Unit	Total Cost/Year
Case Management	77	1,299 (15 min.)	$ 15.87	$ 1,587,365
Respite Care	21	27 (1 day)	271.54	153,963
Modifications	25	1 (once/year)	1020.00	25,500
Family Counseling	11	36 (15 min.)	15.61	6,182
Family Training	60	36 (15 min.)	6.51	14,062
Homemaker	33	925 (1 hour)	8.32	253,968
Foster Care	15	267 (1 day)	20.81	83,344
Extended MA Services:				
Nursing	70	5,845 (1 hour)	22.50	9,205,875
Home Health Aide	15	3,896 (30 min.)	4.68	273,499
Physical Therapy	58	624 (15 min.)	11.22	406,074
Occupational Therapy	58	624 (15 min.)	12.24	442,990
Speech Therapy	39	624 (15 min.)	11.48	279,377
Nutritional Therapy	18	48 (15 min.)	5.87	5,072
Respiratory Therapy	40	1,248 (15 min.)	8.93	445,786
Physician	77	24 (visit)	82.62	152,682
Prescribed Drugs	34	36 (item)	10.20	12,485
Supplies/Equipment	77	240 (item)	125.89	2,326,447
Transportation	6	10 (1 trip)	15.00	900
GRAND TOTAL				$15,675,570

Total Estimated Expenditures	$15,675,570
Individuals Served	77
Average per Individual	$203,579

F

Year Four SERVICE	Number of Individuals	Average Units of Service/Individual	Average Cost per Unit	Total Cost/Year
Case Management	90	1,306 (15 min.)	$ 16.19	$ 1,902,973
Respite Care	25	27 (1 day)	276.97	186,955
Modifications	29	1 (once/year)	1020.00	29,580
Family Counseling	13	36 (15 min.)	15.92	7,451
Family Training	70	36 (15 min.)	6.64	16,733
Homemaker	39	930 (1 hour)	8.49	307,932
Foster Care	18	268 (1 day)	21.23	102,414
Extended MA Services:				
Nursing	82	5,877 (1 hour)	22.50	10,843,065
Home Health Aide	18	3,918 (30 min.)	4.77	336,399
Physical Therapy	68	624 (15 min.)	11.22	476,087
Occupational Therapy	68	624 (15 min.)	12.24	519,368
Speech Therapy	46	624 (15 min.)	11.48	329,522
Nutritional Therapy	21	48 (15 min.)	5.87	5,917
Respiratory Therapy	47	1,248 (15 min.)	8.93	523,798
Physician	90	24 (visit)	82.62	178,459
Prescribed Drugs	40	36 (item)	10.20	14,688
Supplies/Equipment	90	240 (item)	128.41	2,773,656
Transportation	6	10 (1 trip)	15.00	900
GRAND TOTAL				$18,555,896

Total Estimated Expenditures	$18,555,896
Individuals Served	90
Average per Individual	$206,177

G

Year Five SERVICE	Number of Individuals	Average Units of Service/Individual	Average Cost per Unit	Total Cost/Year
Case Management	102	1,324 (15 min.)	$ 16.51	$ 2,229,642
Respite Care	28	27 (1 day)	282.51	213,578
Modifications	33	1 (once/year)	1040.40	34,333
Family Counseling	15	36 (15 min.)	16.24	8,770
Family Training	79	36 (15 min.)	6.77	19,254
Homemaker	44	943 (1 hour)	8.66	359,321
Foster Care	20	272 (1 day)	21.65	117,776
Extended MA Services:				
Nursing	93	5,958 (1 hour)	22.50	12,467,115
Home Health Aide	20	3,972 (30 min.)	4.87	386,873
Physical Therapy	77	624 (15 min.)	11.44	549,669
Occupational Therapy	77	624 (15 min.)	12.48	599,639
Speech Therapy	52	624 (15 min.)	11.71	379,966
Nutritional Therapy	24	48 (15 min.)	5.99	6,900
Respiratory Therapy	53	1,248 (15 min.)	9.11	602,572
Physician	102	24 (visit)	84.27	206,293
Prescribed Drugs	45	36 (item)	10.40	16,848
Supplies/Equipment	102	240 (item)	130.98	3,206,390
Transportation	6	10 (1 trip)	15.00	900
GRAND TOTAL				$21,405,839

Total Estimated Expenditures	$21,405,839
Individuals Served	102
Average per Individual	$209,861

H

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

MAY 13 1985



Mr. Leonard W. Levine
Commissioner
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, Minnesota 55101

Dear Mr. Levine:

I am pleased to inform you that your request for Medicaid waivers to provide home and community-based services to eligible Medicaid recipients as authorized under the provisions of section 1915(c) of the Social Security Act, has been approved.

Specifically, you submitted a model waiver request to provide case management, respite care, environmental modifications to the home, homemaker, family counseling and training and foster care services to categorically, optional categorically and medically needy chronically disabled children under 21 years of age who would otherwise require institutional care in a skilled nursing facility which is unavailable, necessitating hospitalization. You also asked for a waiver of section 1902(a)(10) of the Social Security Act.

Based upon the assurances you provided, I approve the revised model waiver request cited above for a 3-year period effective April 1, 1985. With a satisfactory showing, the waiver may be renewed at the end of the initial 3-year period.

On March 13, 1985 final regulations were published in the Federal Register which replace the interim final regulations which were published for this program on October 1, 1981. Regulations at 42 CFR 441.302(e)(2) provide that the agency's total expenditures for home and community-based services under the waiver and its claim for Federal financial participation in expenditures for services will not exceed the agency's approved estimates for these services, expressed as the product of (C x D) in the supporting documentation for each year of the waiver period. Our records indicate the following limits will become effective on June 11, 1985:

Year 1 (April 1, 1985 to March 31, 1986): $2,052,736
Year 2 (April 1, 1986 to March 31, 1987): $4,381,088
Year 3 (April 1, 1987 to March 31, 1988): $7,366,150

The limit for the first waiver year will be prorated and not applied retroactively. While we are accepting these estimates on the basis of the documentation submitted with your waiver request, we believe that they may need to be reconsidered for years 2 and 3 on the basis of your operating experience during the first year. Accordingly, we plan to monitor your expenditures under the waiver and reserve the right to require you to revise the estimates for years 2 and 3. You, of course, may also revise them on your own motion through a waiver amendment.



The model waiver request, as revised, conforms fully to the requirements of the statute and Medicaid regulations. You can be proud of the fact that the effort and cooperation provided by you and your staff enabled us to expedite our approval.

Sincerely yours,

Carolyne K Davis

Carolyne K. Davis, Ph.D.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
444 LAFAYETTE ROAD
ST. PAUL, MINNESOTA 55101

OFFICE OF THE COMMISSIONER
612/296-2701

GENERAL INFORMATION
612 296-6117

March 25, 1985

PLEASE REPLY TO _____

Carolyn Davis, Ph.d., Administrator
Health Care Financing Administration
Department of Health & Human Services
6325 Security Blvd.
Baltimore, MD 21207

Re: Home & Community-Based Waiver
Request for Chronically Ill Children

Dear Ms. Davis:

I have attached our most recent changes to Minnesota's waiver for chronically ill children after further discussion with Mary Chanski of your staff.

I have added a page before Attachment I that responds to the eligibility questions raised in the HCFA review process as well as an additional statement regarding treatment of income and resources on the application. Also, I am requesting that the effective date be changed to April 1, 1985.

If there are further questions, please contact me.

Sincerely,

Anne Bruggemeyer
Long Term Care Management

ABB:lmw

cc: Judith Stec
Regional Administrator
Department of Health & Human Services
Health Care Financing Administration
175 W. Jackson Blvd., Suite A-835
Chicago, IL 60604

Mary Chanski
Room 411 East High Rise
Health Care Financing Administration
6325 Security Blvd.
Baltimore, MD 21207

Attachments

AN EQUAL OPPORTUNITY EMPLOYER

state medicaid manual
Part 4 — Services

Department of Health and Human Services
Health Care Financing Administration

Transmittal No. 2 Date December 1982

NEW MATERIAL	NO. OF PAGES	REPLACED PAGES
Sec. 4440	7 pp.	—

NEW POLICY—EFFECTIVE DATE: November 15, 1982

Section 4440. Home and Community-Based Services.—Secretary Schweiker recently wrote to the Governors of every State encouraging them to participate in a special targeted program for certain disabled individuals. These are patients who could be satisfactorily-treated at home, at less expense to the Government, but who remain institutionalized to avoid losing Medicaid eligibility. A number of options are available for States to help these people and reduce the cost burden on Government programs. First, under section 1902(e) of the Act, as added by section 134 of the Tax Equity and Fiscal Responsibility Act of 1982, a State has the option of covering under Medicaid disabled children age 18 or under who are living at home who would be eligible for SSI or State supplementary payment, and therefore Medicaid, if they were in a medical institution. This provision is effective October 1, 1982. Separate instructions will be issued on this provision in the near future. Second, we have established a board within the Department to review individual applications for SSI (not limited by age) submitted by the States. Guidelines for this approach were published in the Federal Register on June 4, 1982, and sent to you as Transmittal No. 82-13, July 1982.

Third, using the authority of the Omnibus Budget Reconciliation Act of 1981, a State can offer, under a Secretarial waiver, home and community-based services to individuals who otherwise would require institutionalization. Regulations implementing these provisions were published in the Federal Register on October 1, 1981. (Section 1902(a)(10(A)(ii)(VI) of the Act, as added by Section 137(b)(7) of the Tax Equity and Fiscal Responsibility Act of 1982 permits coverage as optional categorically needy for the individuals who will receive home and community-based services under the waiver, and who, if they did not receive home and community-based services, would require institutional care.) Accordingly, if an individual would qualify for Medicaid in the institutional setting because the income of the parents or of a spouse was not deemed available to the individual, a State may elect this optional coverage group and apply these same deeming rules when determining eligibility for home and community-based services. This option allows States to eliminate situations where individuals must remain institutionalized to retain Medicaid eligibility even though the recipient could receive the necessary services at home, and at a lower cost to Medicaid.

This instruction deals with the third option: the use of the home and community-based waiver. To assist you in utilizing this opportunity to avoid unnecessary institutionalization and reduce expenses, we have developed a model waiver request (Exhibit A) that you can submit in addition to or in lieu of a regular home and community-based waiver request just for those blind and disabled children and adults who would otherwise be ineligible for Medicaid while living at home because of the SSI deeming rules.

We believe it is very important for States to use the home and community-based waiver process to establish coverage for this targeted group in the community. Please note that the model request relates specifically to those blind and disabled individuals, as determined by the State, who have or would have established eligibility for Medicaid services based on institutionalization, and that the sole purpose of the request is to provide authority for the State to furnish such individuals with services in the home and community setting. A State would be required to offer at least one home and community-based service under the model request, e.g., case management services, in addition to those services that are now included in the State's Medicaid plan. States must meet all the basic statutory and regulatory requirements for waivers. However, we expect that use of the model request will simplify State preparation of these submissions and permit expedited review and approval.

States are limited to a total of up to 50 cases for each model request. States wishing waivers to cover larger numbers of recipients or to provide a comprehensive range of services should utilize the regular home and community-based services waiver system or submit another model waiver request. This separation between model waiver requests and other waiver requests will enable us to process both types of requests more efficiently. Model requests should be submitted to Central Office. The information collections contained in this issuance require OMB approval. HCFA will begin to process model waiver requests after it has received OMB approval.

We urge your support in this effort. By requesting a waiver you can obtain the appropriate authority to fund alternatives to institutional care and potentially achieve significant cost savings in your State's Medicaid program.

If you have any questions or comments, please contact: Robert E. Wren, Director, Division of Provider Services Coverage Policy, Office of Coverage Policy, BPP, 6325 Security Boulevard, Baltimore, Maryland 21207. Telephone Number FTS-934-9820 or (301) 594-9820.

4440. HOME AND COMMUNITY-BASED SERVICES.

A. Background.—Using the authority of the Omnibus Budget Reconciliation Act of 1981, (P.L. 97-35), a State can offer, under a Secretarial waiver, home and community-based services to individuals who otherwise would require institutionalization. Regulations implementing these provisions were published in the Federal Register on October 1, 1981. (Section 1902(a)(10(A)(ii)(VI) of the Act, as added by Section 137(b)(7) of the Tax Equity and Fiscal Responsibility Act of 1982 permits coverage as optional categorically needy for the individuals who will receive home and community-based services under the waiver, and who, if they did not receive home and community-based services, would require institutional care.) Accordingly, if an individual would qualify for Medicaid in the institutional setting because the income of the parents or of a spouse was not deemed available to the individual, a State may elect this optional coverage group and apply these same deeming rules when determining eligibility for home and community-based services. This option allows States to eliminate situations where individuals must remain institutionalized to retain Medicaid eligibility even though the recipient could receive the necessary services at home, and at a lower cost to Medicaid.

B. Model Waiver Request.—To assist States in utilizing the home and community-based waiver process to avoid unnecessary institutionalization and reduce expenses, a model waiver request (Exhibit A) can be submitted in addition to or in lieu of a regular home and community-based waiver request just for those blind and disabled children and adults who would otherwise be ineligible for Medicaid while living at home because of the SSI deeming rules. Please note that the model request relates specifically to those individuals, as determined by the State, who have or would have established eligibility for Medicaid services based on institutionalization, and that the sole purpose of the request is to provide authority for the State to furnish such individuals with services in the home and community setting. A State would be required to offer at least one home and community-based service under the model request, e.g., case management services, in addition to those services that are now included in the State's Medicaid plan. States must meet all statutory and regulatory requirements for waivers that were published in the Federal Register on October 1, 1981.

States are limited to a total of up to 50 cases for each model request. States wishing waivers to cover larger numbers of recipients or to provide a comprehensive range of services should utilize the regular waiver system or submit another model request. This separation between model waiver requests and other waiver requests will enable us to process both types of requests more efficiently. Questions concerning the model requests should be submitted to the Director, Division of Provider Services Coverage Policy, Office of Coverage Policy, BPP, 6325 Security Boulevard, Baltimore, Maryland 21207. Telephone Number FTS-934-9820.

C. Instructions for Completing a Model Waiver Request.—Many of the items in the model waiver request (Exhibit A) do not need any additional information from the States and are required by the statute or regulations. The State official's signature on the request indicates the State's agreement and acceptance of the particular item.

1. Heading. Enter the name of the State.

2. Item 1. No information required.

3. Item 2. In order to obtain approval of its model waiver request, the State must provide to recipients under the waiver at least one home and community-based service, e.g, case management services, in addition to those services already provided for in its State Medicaid plan. The State may also request approval under the model waiver request to provide other home and community-based services; however, we would note that the addition of such services will necessitate additional documentation.

The State may request approval to provide one or more of the following services: case management services, homemaker services, home health aide services, personal care services, adult day health services, habilitation services, respite care services, and other cost-effective home and community-based services. The State must attach to its model waiver request a complete description and definition of each service that it proposes to offer.

4. Item 3. Enter the categories the State wishes to include under the waiver: categorically needy, optional categorically needy, or medically needy.

The State may wish to provide home and community-based services to blind or disabled individuals who are 18 years of age or less under the model waiver request if it does not opt to cover them under section 1902(e) of the Act, as added by section 134 of the Tax Equity and Fiscal Responsibility Act of 1982. Under this provision, a State has the option of covering under Medicaid disabled children age 18 or under who are living at home who would be eligible for SSI or a State supplementary payment, and therefore Medicaid, if they were in a medical institution. This provision is effective October 1, 1982. However, even if the State covers such individuals under the 1982 provision, it may also wish to cover them under the model waiver request so it can provide this group home and community-based services which are not otherwise included in its State Medicaid plan. Further, under the model waiver, the States may also be granted a waiver of the statewideness requirement under section 1902(a)(1) and the comparability requirements under section 1902(a)(10) of the Act.

5. Item 4. No information required.

6. Item 5. Check yes or no. If yes is checked, show which geographic subdivisions (e.g., counties) will be included.

7. Item 6. Attach a description of the qualifications of the individuals who will be responsible for developing a recipient's plan of care.

8. Item 7. No information required.

9. Item 8. No information required.

10. Item 9. No information required.

11. Item 10. Enter the name of the State.

To comply with item 10(a), the State must submit a description of how it will assure the health and welfare of the recipients of home and community-based services. Further, the State must provide copies of any standards for providers of services under the waiver and residential standards if the services will be provided to recipients in facilities other than a private residence (unless these standards were submitted to HCFA for a previously approved waiver request).

To comply with item 10(b), the State must submit a description of how it will assure an audit trail of funds expended under the waiver and include a description of the records and information that will be maintained to assure financial accountability.

To comply with item 10(c), the State must submit a copy of the instrument it will use to evaluate the recipients' need for the level of care provided in an ICF (including an ICF/MR) or SNF. Also describe how written documentation of the evaluations and reevaluations will be maintained (e.g., as part of the patient's permanent case file).

As part of its compliance with item 10(d), the State must assure that it will provide a fair hearing as specified under 42 CFR Part 431, subpart E, for any beneficiary who is denied the service of his or her choice available under the waiver or under the plan.

To comply with item 10(e), the State must develop an estimate, based on actual utilization and cost data, of the cost of the individual's care in the institution as compared with the cost of that individual's care in the home or community setting. These estimates are to be provided in accordance with the equation specified in 42 CFR 441.303(d). This estimate is to include cost and data on the number of individuals (up to 50) the State will provide home and community-based services. Estimates of nursing home cost and utilization should be drawn from actual experience and from the most recent figures shown by the State in its HCFA Form 2082, unless the State has an equally reliable source of alternate data.

No further information is needed for items 10(f) and 10(g).

12. Item 11. If requested by the State, a waiver becomes effective no earlier than the date on which the State met the substantive requirements for a waiver, unless the agency requests that the waiver become effective at a later date. However, in no event will an effective date be retroactive prior to the first day of the quarter in which an approvable request is submitted, as long as the State met all the substantive requirements on that date. If no date is requested, the effective date is the date the agency is notified the request has been approved.

MODEL WAIVER REQUEST

EXHIBIT A

Special Targeted Home and Community-Based Services Waiver

State Minnesota

1. A waiver is requested for a 3-year period under section 1915(c) of the Social Security Act to provide home and community-based services to individuals who would otherwise require the level of care provided in a skilled nursing facility or intermediate care facility, the cost of which could be reimbursed under the State Medicaid plan.

2. The State requests that the following home and community-based service be included under this waiver request:

case management

Other home and community-based services the State proposes to offer are:

Respite care, environmental modifications to the home, homemaker, family counseling and training and foster care

A complete description and definition of all home and community-based services to be provided under this waiver is attached.

See Attachment I

3. The sole purpose of this request is to provide authority for the State to furnish the requested services in the home and community setting to no more than 50 individuals who would be Medicaid-eligible if institutionalized. These individuals will be from among the following categories: Categorically, optional categorically and medically needy chronically disabled individuals. A waiver of Section 1902(a)10(c)(i)(III) of the Social Security Act is requested to allow use of the institutional deeming requirements for the medically needy population.*

Under authority of section 1902(a)(10)(A)(ii)(V1), such individuals would be eligible for Medicaid services even if they would otherwise be ineligible for Medicaid while living at home because of the SSI deeming rules. Such individuals include:

(a) Blind or disabled children with an ineligible parent(s) where income deemed from the parent(s) would cause the applicant to be ineligible for SSI if the family shared a household; and

(b) Blind or disabled individuals with an ineligible spouse where income deemed from the spouse would cause the applicant to be ineligible for SSI if the family shared a household.

4. A waiver of the amount, duration, and scope requirements in section 1902(a)(10) of the Act is requested.

5. A waiver of the statewideness requirements in section 1902(a)(1) of the Act is requested.

a. __X__ No.

b. _____ Yes. Waivers will apply to individuals only in the following geographic subdivisions:_____

*Minnesota will use institutional rules for deeming of income and resources so the parent/spousal income and resources will not be deemed beginning the first full calendar month of entrance into the waiver program.

6. An individual written plan of care will be developed by qualified individuals for each recipient covered under this waiver. This plan of care will describe the services to be furnished, their frequency, and the type of provider who will furnish them. The plan of care will be subject to the approval of the State Medicaid agency. (A description of the qualifications of the individuals who will be responsible for developing the plan of care is attached.) (See Attachment II)

7. The services will not be furnished to recipients while they are inpatients of a hospital, SNF, ICF, or ICF/MR.

8. Federal financial participation for services will not be available in expenditures for the cost of room and board except when provided as part of respite care in a facility approved by the State that is not a private residence.

9. The State will refuse to offer home or community-based services to any recipient for whom it can reasonably be expected that the cost of home or community-based services furnished to that recipient would exceed the cost of the level of care provided in an SNF, ICF or ICF/MR.

10. The Minnesota Medicaid agency provides the following assurances to HCFA:

(a) Necessary safeguards have been taken to protect the health and welfare of the recipients of the services. Those safeguards include adequate standards for provider participation. All State licensure or certification requirements for services or for individuals furnishing services provided under the waiver will be met. (A description of the safeguards is attached.) (See Attachment III)

(b) The agency will assure financial accountability for funds expended for home and community-based services, and it will maintain and make available to HHS, the Comptroller General, or their designees, appropriate financial records documenting the cost of services provided under the waiver. (A description of the records and information that will be maintained is attached.) (See Attachment IV)

(c) The agency will provide for an evaluation of the need for home and community-based care for recipients who are entitled to the level of care provided in an SNF or ICF (including an ICF/MR), as defined by 42 CFR §§440.40 and 440.150 respectively, and for whom there is a reasonable indication that they might need such services in the near future. Written documentation of all evaluations will be maintained. (A description of the agency's plan for evaluation and a copy of the evaluation instrument is attached.)

(See Attachment V)

(d) If a recipient is determined to be likely to require the level of care provided in an SNF, ICF, or ICF/MR, the recipient or his or her representative will be informed of the feasible alternatives, if any, available under the waiver, and permitted to choose among them. The agency will provide for a fair hearing as specified under 42 CFR Part 431, subpart E, for any recipient who is denied the service of his or her choice available under the waiver or under the plan.

(e) The fiscal year expenditures for each case under the waiver will not exceed the expenditures for the level of care provided in an SNF, ICF, or ICF/MR under the State plan that would have been made in that fiscal year had the waiver not been granted. (An explanation with supporting documentation as described in 42 CFR 441.303(d) is attached.)

(See Attachment VI)

(f) The quality of medical care necessary for the individual will be maintained under the arrangements contemplated.

(g) The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of recipients. The information will be consistent with a data collection plan designed by HCFA. For purpose of this special waiver, data will be maintained on the cost and utilization of services for each individual.

11. An effective date of April 1, 1995 is requested.

Signature : Albert Hawes

Title : Ass. Commissioner

Date : 2-28-95

Rev. 2

U. S. GOVERNMENT PRINTING OFFICE: 1983-381-438:63

CLARIFICATION OF ELIGIBILITY
ISSUES FROM HCFA REVIEW

Minnesota covers disabled children as disabled and applies the SSI deeming requirements to these children. Attachment 2.2A, page 4 of the State Plan will be changed this quarter to reflect this practice. Part of the waiver application includes a deeming waiver for children under age 18 residing at home.

Medicaid eligibility for waiver eligible individuals is consistent with eligibility determinations. Waiver eligible clients must meet the financial and non-financial Medicaid eligibility criteria in the approved Minnesota State Plan.

Minnesota is a 209b state and all disability standards used conform to 42 CFR 435.12.

Persons receiving SSI as blind or disabled are presumed to meet the disability standards.

We agree to add the optional categorically needy to the waiver. SSI children in an AFDC family are Medicaid eligible.

5/13/85

DESCRIPTION OF WAIVERED SERVICES FOR ELIGIBLE INDIVIDUALS

CASE MANAGEMENT

Case Management is a set of services provided by a trained professional to coordinate and arrange services for clients. Case management services include: (1) preliminary screening to determine client eligibility; (2) comprehensive assessment to determine client characteristics and services needs; (3) care plan development to select the duration scope and intensity of services (numbers(2) and (3) will be accomplished in consultation with the discharge team); (4) arranging and referring the client to services; (5) monitoring the client to verify the appropriateness of services rendered; and (6) reassessing the care plan at least every six months against the current needs of the client. The case manager cannot have a financial interest in the services provided to the individual unless the case manager is a county staff person. Furthermore, duplicate payments will not be made for case management services by more than one provider.

ENVIRONMENTAL MODIFICATIONS IN THE HOME

Environmental Modifications are physical adaptations to the home as indicated in the patient plan of care. Examples of this include modifications in electrical wiring to accommodate equipment, construction of wheelchair ramps, widening of doors, adaptation of storage or living space to accommodate equipment and other changes as indicated in the plan of care and approved and authorized by the case manager. All adaptations will be completed in accordance with all applicable state and city building codes by a contractor which has been approved by the case manager.

FAMILY COUNSELING AND TRAINING

Family Counseling and Training includes counseling for family members as approved by the case manager for issues pertaining to maintenance of the individual in the home setting and training in the use of equipment and treatment regime as indicated in the plan of care for at least two caregivers; with updates as necessary to maintain safe care of the individual in the home setting. Counseling may include: crisis, family and individual counseling and would be assessed as required for family functioning to maintain the individual at home. Family counseling and training services will be provided by a county social worker, a medical social worker, the individual's physician, a registered professional nurse, or a public health nurse.

FOSTER CARE

Foster Care Services are defined as the provision of ongoing residential care and supportive services to enable the individual to be discharged from the hospital into other than his/her natural family unit. Foster care providers must meet current state licensure requirements; training shall be provided and updated as necessary. Foster care does not include the cost of room and board and FFP will not be claimed by the state for these services. Minnesota's funding received through the Title IV-E Program is used to make payments for room and board. FFP for waivered services will not be used to supplant this funding source.

HOMEMAKER/SERVICES

Homemaker Services consist of general household activities provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage them for himself or others under the direction of a registered nurse. Activities may include: (1) meal planning, preparation and cleanup; (2) tidying, dusting, sweeping, and vacuuming; (3) cleaning counters, cupboards and appliances; (4) laundering, ironing and mending; (5) performing essential shopping and errands; (6) assisting with bathing, toileting, grooming, eating and ambulating; (7) providing companionship, emotional support and social stimulation; and (8) arranging for transportation.

RESPITE CARE

Respite Care is a temporary service provided by trained, qualified personnel, on a regular or intermittent basis, for the purpose of relieving the family of the care of a dependent person for short, specified periods of time. Respite care may be provided in the home, by a registered professional nurse, or public health nurse, in the hospital or SNF facility and has as its purpose: 1) the meeting of planned or emergency family needs; 2) the restoration or maintenance of the physical and mental well-being of the individual and/or the family; or 3) providing supervision, companionship and personal care to the individual for the specified period of time. Room and board will not be included in the cost of respite care in the home.

SERVICES TO BE ALLOWABLE BY EXTENDING CURRENT MINNESOTA MEDICAL ASSISTANCE PROGRAM LIMITATIONS:

The Department is requesting a waiver of 1902(a)(10) of the Social Security Act without state plan modifications so these individuals can remain at home.

HOME HEALTH SERVICES

Home Health Services are defined in accordance with the State Plan except that limitations on the number of visits, hours reimbursed, and on intermittent care or part-time care do not apply. All safeguards and provider standards continue to apply. Limitations on the amount, duration and scope of home health services will be specified in the individual patient care plan. All home health services provided to waiver recipients must be authorized in the patient care plan. Providers reimbursed under the waiver program include, but are not limited to, the following:

- Physician Services: Reimbursement for physician services as currently indicated under Medical Assistance and enlarged to include home visits as authorized in the plan of care and/or indicated by the case manager to maintain safe care of the individual in the home or alternate setting.

- Professional Nursing Services: Nursing services consistent with the Minnesota Nursing Act for individuals who require more individual and continuous care than is available from a visiting nurse, which are provided by a registered nurse or a licensed practical nurse; includes training in the use of prescribed equipment needed for the individual. The amount and professional background of nursing services required will be initially indicated by the hospital discharge planning team and will be evaluated periodically or as needed by the case manager.

- Public Health Nursing: Home visits to the individual and/or his or her family made by licensed personnel of the county public health nursing agency; nature and frequency of visits to be indicated by the discharge team in the plan of care and/or the case manager.

OTHER PROFESSIONAL SERVICES

Waiver recipients are eligible for physical, occupational, speech, respiratory, and nutritional therapies provided for in-state plan services. Current safeguards and provider standards will continue to apply for all therapies covered under this section. Limitations on the amount, duration and scope of therapies for waiver recipients will be specified in the patient care plan.

Medical Equipment and Supplies which are generally available to the individual in the institution are covered under the waiver for home use. Limitations on the types of equipment or supplies available under the State Plan for durable medical equipment and supplies will not apply; however, all requirements for rental, purchase and safeguarding of patient care continue to apply. Medical equipment and supplies in excess of $25.00 value require prior authorization in the patient care plan.

PRESCRIBED DRUGS

All prescription drug products available to the individual as an inpatient will be available to participants subject to prior authorization by the attending physician as evidenced in the patient care plan. Waiver program participants will be eligible for prescription medications in accordance with current State Plan requirements except that limitations on the number of prescriptions which may be filled or refilled per month shall not apply.

TRANSPORTATION

Transportation for medical purposes is provided to waiver recipients as indicated in the plan of care or approved by the case manager. Types of transportation will vary according to the needs of the individual specified in the patient care plan. Transportation will be required because not all services will be provided in the home (i.e., physician, therapy).

ATTACHMENT II

QUALIFICATIONS OF INDIVIDUALS RESPONSIBLE FOR DEVELOPING PLAN OF CARE

The individual plan of care will be developed and approved by the recipient's discharge planning team.

The discharge planning team includes the following members:

The attending medical specialist (MD)
Primary Nurse (RN)
Medical social worker
Occupational therapist
Physical therapist
Speech therapist
Respiratory therapist
Nutritionist
Parents/Spouse or legal guardian
County public health nurse
County social worker
* Representative from Services for Children with Handicaps (for individuals under 21 years of age)

* (This is the Title V MCH agency in Minnesota.)

(Please also refer to Attachment V for description of client intake.)

DESCRIPTION OF SAFEGUARDS

All state licensure and certification requirements for services or individuals providing services will be met.

QUALIFICATIONS OF PROVIDERS OF WAIVERED SERVICES

County Social Worker - Qualifications

A county social worker is a graduate of a school of social work accredited by the Council on Social Work Education, (or has a B.A. degree from an accredited college plus a minimum of three years experience as a social worker) is currently employed by the Council on Social Work Education, is currently employed by the county social service agency where the individual will reside and has knowledge of community resources for individuals with special needs.

Foster Care Provider - Qualifications

Medical foster home providers shall be currently licensed by the State Department of Human Services and shall meet all current standards and requirements of the Department.

Home Health Aide - Qualifications

A home health aide is certified by a Technical-Vocational Institute after taking or testing out of a 60-hour certified course developed by the Minnesota Department of Health.

Homemaker - Qualifications

Each homemaker shall have a 25-hour pre-service training program provided by the vendor agency and certified by the county agency.

Medical Social Worker - Qualifications

A medical social worker is a graduate of a school of social work accredited by the Council on Social Work Education and has had social work experience in a hospital, outpatient clinic, medical rehabilitation or medical care program.

Occupational Therapist - Qualifications

An occupational therapist is registered by the American Occupational Therapy Association or is a graduate of a program in occupational therapy approved by the Council of Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association and engaged in the required supervised clinical experience period prerequisite to registration by the American Occupational Therapy Association.

Occupational Therapy Assistant - Qualifications

An occupational therapy assistant has successfully completed a training course approved by the American Occupational Therapy Association and is certified by that body as a certified occupational therapy assistant.

Physician - Qualifications

Physicians shall meet all current licensure and reimbursement mechanisms necessary for the State of Minnesota.

Professional Nursing Services - Qualifications

A practical nurse or vocational nurse (LPN) is licensed by the State of Minnesota and preferably has at least one year of nursing experience under the supervision of a registered professional nurse.

A registered professional nurse (RN) is currently licensed by the State of Minnesota as a registered professional nurse and preferably has one year of experience as a professional nurse.

Public Health Nurse - Qualifications

A public health nurse is licensed to practice professional nursing in the State of Minnesota and has completed a baccalaureate degree program approved by the National League for Nursing for Public Health Nursing preparation or post-baccalaureate study which includes content approved by the National League for Nursing for public health nursing preparation.

Respiratory Therapist - Qualifications

A respiratory therapist is a graduate of a program in respiratory therapy approved by the Council of Medical Education of the American Medical Association in collaboration with the American Respiratory Therapy Association, or its equivalent, and, when applicable is certified by the State of Minnesota.

Speech Therapist - Qualifications

A speech therapist is certified by the American Speech and Hearing Association, or has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for certification.

Nutritionist - Qualifications

A nutritionist is a registered dietician with at a minimum has a bachelors degree and must be registered by the Commission of Dietetic Registration.

RECORDS AND INFORMATION

The Minnesota Department of Human Services will make payments to providers of services to individuals under this waiver through the state's approved Medicaid Management Information System. Many of the current program edits that assure the integrity of this reimbursement system will be maintained. Each client's billing information can be retrieved by use of the client's specific MA-ID number. Furthermore, Minnesota has created a data-base, collecting reporting information for screening that is merged with payment information on providers of waivered services. All waivered service providers will be required to maintain client specific records as well as service agreements substantiating billing to the department, and these records will be maintained for, at a minimum, five years.

MINNESOTA'S PLAN FOR EVALUATION AND EVALUATION INSTRUMENT

Referrals to the Waiver Program normally will arise from the individual's tertiary care facility clinical staff, although community members and/or parents, spouses or legal guardians can initiate the intake process. When home and community placement becomes a realistic option for the individual and his/her family, a referral will be made to the Waiver Unit of the Health Programs Section, State Department of Human Services, who will verify Medical Assistance eligibility and begin to arrange the required evaluation for eligibility into the waiver program.

The tertiary care facility discharge planning team will identify both current services received and future services needed through the individual's discharge plan. This discharge plan will provide background for the development of an individual plan of care developed by members of the hospital discharge team and key community providers.

HOSPITAL DISCHARGE PLANNING TEAM

Each individual's health service needs and functional abilities will be comprehensively assessed by the hospital discharge planning team. The individual's case manager will be the primary nurse, the medical social worker, the county social worker or county public health nurse.

The hospital discharge planning team membership will depend on the individual's specific service needs but should include the following disciplines:

- Case Manager;
- Parent/guardian or spouse of the individual;
- Attending medical specialist/responsible physician;
- Primary nurse;
- Medical social worker;
- County social worker;
- Occupational therapist;
- Speech therapist;
- Respiratory therapist;
- Physical therapist;
- Nutritionist;
- County public health nurse; and
- Services for Children with Handicaps representative. (for individuals under 21 years of age)

Obligatory hospital discharge planning team members include the following:

- Case Manager;
- Parent/guardian or spouse of the individual;
- Attending medical specialist/responsible physician;
- Primary nurse (RN);

- Medical social worker:
- County social worker:
- County public health nurse: and
- Services for Children with Handicaps representative. (for individuals under 21 years of age)

The assessment process will consider such factors as: the continued level of institutional care that the individual would require: family capacity for managing the individual's activities of daily living; household: formal and informal support systems available in the home: family environment and individual's mental functioning: financial resources available: and physical environment in addition to the individual's health care requirements. If a client is not found eligible for services, FFP will not be claimed for the cost of screening/assessment.

This representative will be a public health nurse or a medical social worker. (See Qualifications.)

The hospital discharge planning team will develop an individual patient plan of care for those services which would be essential to provide smooth entry for the individual and his/her family into the home and community-based setting. This treatment plan will include the medical and all other services to be provided, their frequency and duration, and the type of certified providers who may furnish those services. The patient care plan must be approved in writing by the case manager, individual's parent, spouse or legal guardian and attending physician. This plan of care and associated costs will be sent to the Department of Human Services so overall cost projections can be monitored. (See Appendix A for Plan of Care format.)

The discharge planning team would continue to be a resource to the community-based physician, the case manager and members of the community interdisciplinary team: a specific individual designated for ongoing contact with the case manager would be identified before discharge.

CASE MANAGER

The hospital discharge planning team, based on the patient's individual needs and resource availability, will identify the appropriate professional discipline of the case manager. The discharge planning team, in consultation with service providers from the individual's county of residence will identify the specific individual who would agree to assume the role of case manager. The State Department of Human Services Waiver Program will monitor vendor payment accountability with the assistance of the assigned case manager. The State Department of Human Services has the overall responsibility for maintaining costs under the waiver. Case manager responsibilities shall include the following:

- Provide the individual and/or family with information about care choices, available services, recipient rights;
- Coordinate services to avoid duplication and fragmentation;
- Initiate referrals as appropriate to the client plan of care and current family needs;

- Assume responsibility for regular evaluation of client condition and family functioning as specified in the plan of care;
- Assure the coordination of billing for waivered services through the Waiver Unit of the Department of Human Services; and
- Coordinate communication and information flow between community interdisciplinary team delivering services to individual, tertiary care facility responsible for individual and Department of Human Services Waiver Unit caseworker.

COMMUNITY INTERDISCIPLINARY TEAM

To facilitate the transition from the tertiary care setting to the individual's home and community environment, an interdisciplinary team will be identified within the community to develop and implement a community service program based on the individual plan of care developed by the center discharge planning team. Liaison should be established between the center-based responsible physician and the community-based physician who will be responsible for the individual's ongoing medical care needs. Liaison should also be established and maintained between the tertiary care facility primary nurse who is a member of the hospital discharge planning team and the county public health nurse to facilitate smooth entry into the local community service network.

This community interdisciplinary team may include, but is not limited to, the following members:

- Case manager;
- Parent/guardian or spouse of the individual;
- Primary caretaker (if different from above);
- Community-based responsible physician;
- County social worker;
- County public health nurse;
- Services for Children with Handicaps regional representative (for individuals under 21 years of age); and
- Liaison from the discharge planning team.

Please see Appendix B for a copy of the Evaluation Instrument to be used by Discharge Planning team when evaluating individuals for waiver program eligibility. Also included is a Physical Facility Checklist for the Home (Appendix C) to be completed by the assigned case manager.

A formal assessment of each individual will be completed by the case manager in conjunction with the community interdisciplinary team every six months.

Appendix A

COMMUNITY ALTERNATIVE CARE PROGRAM
SERVICES REQUIRED TO CARE FOR INDIVIDUAL IN THE COMMUNITY

Individual's Name _____ Birthdate _____ Date Completed _____

SERVICE	Start-Up Estimated Cost Per Month			On-Going Estimated Cost Per Month			Cost Per Month In Approp. Med. Fac.	RESOURCE FOR PAYMENT 3rd Party	Family	Other	MA	CA
	Units	Hour	Month	Units	Hour	Month						
RN	Hour											
LPN	Hour											
Home Health Aide	Hour											
Case Management	Hour											
Family Counseling	Session											
Family Training	Session											
Therapy:												
Occupational	Visit											
Physical	Visit											
Speech	Visit											
Respiratory	Visit											
Nutritional Supplement	Item											
Prescription Drugs	Item											
Medical Transportation	Trip											

SERVICES REQUIRED TO CARE FOR INDIVIDUAL IN THE COMMUNITY (cont.)

Individual's Name _____ Birthdate _____

SERVICE	Start-Up Estimated Cost Per Month			On-Going Estimated Cost Per Month			Cost Per Month In Approp. Med. Fac.	RESOURCE FOR PAYMENT				
	Units	Hour	Month	Units	Hour	Month		3rd Party	Family	Other	MA	CA
Homemaker	Hour											
Respite	Day											
Physician	Visit											
Home Modifications	Item											
Durable Medical Supplies												
Non-Durable Medical Supplies												
Other												
Other												
Other												
Total												

e:

t per month = daily cost x 365 ÷ 12
t per month = weekly cost x 4.3
t per month = biweekly x 2.16

COMMUNITY ALTERNATIVE CARE PROGRAM
CARE PLAN

To be completed by
fied provider of each
sted service. Make
ional copies as
sary.

Individual's Name _____ Birthdate _____

em	Plan	Outcome	Date to Reevaluate

lake additional
as necessary.

COMMUNITY ALTERNATIVE CARE PROGRAM
Equipment and Supplies Needed in the Community Care Plan

__/__/__
Date

Individual's Name _____ Birthdate _____

RABLE GOODS Item:	FREQUENCY PER MONTH	SUPPLIER	EST. COST PER MONTH	RESOURCE FOR PAYMENT				
				3rd Party	Family	Other	MA	CAL

Total $_____

its:

Make additional as necessary.

Equipment and Supplies Needed in the Community Care Plan

Individual's Name _____ Birthdate _____

E GOODS em:	Start Up	Ongoing	SUPPLIER/Comments	EST. COST PER MONTH	3rd Party	RESOURCE FOR PAYMENT Famil	Other	MA	CA

$_____ $_____

Individual's Name _____ Birthdate _____

Primary Physician

( ) This individual would ~~require~~ reside in an ICU

( ) This individual would require inpatient hospitalization unless home and community based care were provided.

( ) This individual would require an SNF level of care in an inpatient hospital as no SNF would care for this individual.

( ) None of the above.

Individual's overall condition is: ( ) Improving ( ) Stable ( ) Deteriorating ( ) Terminal

In your opinion, how will/has the community plan of care affect/affected the overall condition of the individual?

( ) Good/Excellent ( ) Fair/Good ( ) Poor

( ) Current history and physical are enclosed.

Physician's Certification: I certify that the above-named individual is currently in an inpatient hospital or is at risk of placement in an inpatient hospital. I have been part of the community care planning team and I approve of the community-based service plan. The services, equipment, and supplies are appropriate and necessary for this individual to avoid inpatient hospitalization.

Comments:

Physician Signature: _____ Date _____

Print Physician's Name _____

Complete Address _____

_____

_____

Case Manager: As case manager I: ( ) approve ( ) disapprove of the plan of care to be provided in the community

Comments: - I have determined that program applicant/participant ~~is~~ Recipient/eligible

- I " " that no other 3rd party payers or institutional resources are available for the services. ~~specified herein.~~

Case Manager Signature: _____ Date _____

- " " " Home environment OK.

Signatures and Statements

Parent Spouse or Guardian

Check appropriate response

( ) I/We agree with the total plan of care to be provided in the community. participate in the and request CAC ~~Services~~ ~~program as specified in my Care Plan~~

( ) I/We agree with most of the plan of care and want community services. and request CAC ~~Services~~ ~~specified in my Care Plan~~ with modifications listed be to my care p

( ) I/We agree with most of the plan of care but wish to discuss the plan of care further before initiating or changing community services.

( ) I/We do not wish to have my/our family member in the Community Alternative Care Program

( ) I/We prefer that our family member be cared for in an institutional setting.

Comments: (If additional space is needed for comments, use back of this page and then sign those additional comments.)

Signature of Client or Client Rep.

Appeal Rights

If an individual is determined to be likely to require acute hospital care, the recipient or his or her legal representative will be informed of the feasible alternatives, if any availab under the waiver, and permitted to choose among them. Beneficiaries, or their legal represen tives, who are not given a choice of institutional or waiver services or denied the services choice will be given the opportunity for a fair hearing under 42 CFR Part 431, subpart E. o request a fair hearing, beneficiaries, or their legal representatives, can contact their local agency to write directly to:

Appeals Unit
Department of Human Services
444 Lafayette Road - 3rd Floor
St. Paul, MN 55101

(612) 296-5764

Your Right To Fair Treatment

You have the right to fair, nondiscriminatory treatment. No local agency may discriminate on the basis of color, race, national origin, religion, sex, age, marital status or because of physical, mental or emotional disability. You may file a complaint with the Minnesota Department of Human Services, Centennial Office Building, St. Paul, MN 55155; the Minnesota Department of Human Rights, 500 Bremer Tower, 7th Place and Minnesota St., St. Paul, MN 5510 or the U.S. Department of Health and Human Services, Washington, D.C. 20201.

I have read and ~~I~~ understand the right to appeal under the CAC Program. I understand ~~my~~ the rig to choose where I/my family member will live and how they will receive health care services. have read and I understand my right to fair treatment.

Singature of Client/Parent/Spouse or Guardian or Legal Representative other Date _____

I have discussed the "Appeal Rights" statement with the client and/or Parent/Spouse or Guardi Rt to fair treatment + Plan of Care

Case Manager's Signature _____ Date _____

Appendix B

_____/_____/_____
Date

COMMUNITY ALTERNATIVE CARE PROGRAM

Application

A. IDENTIFYING INFORMATION

Individual's Last Name First Name Middle Initial Date of Birth

APPLICATION INITIATED/REFERRED BY

_____Public Health Nurse
_____Hospital/Acute Care Facility
_____Family
_____Physician
_____Friends/ Neighbors
_____County Welfare
_____Other Professionals
_____Other (Specify)
_____Don't Know

Where is individual currently?

( ) Hospital ( ) Skilled Nursing Facility ( ) Parental Home ( ) Foster Home
( ) Other (Specify) _____

If individual is currently in a medical facility when was he/she admitted?
_____/_____/_____

What is the projected date of discharge? _____/_____/_____

PARENT/SPOUSE/GUARDIAN

Name Relationship

Address Home: Work:
Telephone

Name Relationship

Address Home: Work:
Telephone

MARITAL STATUS

If this is an application for a child under 21 years of age, please indicate marital status of parent/guardian. If this is an application for an individual over 21 years of age or an emancipated child, please indicate marital status of the applicant.

( ) Currently married ( ) Separated ( ) Single, never married
( ) Widowed ( ) Divorced

OTHERS IN THE HOME: List the names, ages, and relationship to the individual of all others who will be living with the individual in the community.

Name	Age	Relationship

B. FINANCIAL BACKGROUND

Please complete the following:

Circle appropriate person	Spouse/Father	Mother	Individual
Income Source	Amount/Month	Amount/Month	Amount/Month
Net Wages			
Social Security - RSDI			
Public Assistance-AFDC, GA, MSA			
Supplemental Security Income-SSI			
Other			
Other			

If the individual is currently not living at home but comes home, will any of the above amounts change? ( ) Yes ( ) No

If yes, how will they change? _____

Individual is covered by:

( ) Private Health Insurance _____
Name of Plan

Policy Number _____

( ) HMO or Prepaid Health _____
Name

Group Number _____

( ) Medicare Claim Number _____

( ) Insurance benefits were exhausted on: _____

Submit copy of policy with this application.

Individual's Medical Assistance Status:

_____ Active _____ Pending _____ Needs Referral _____ Ineligible

/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/ Current ID #

/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/ Waiver ID #

Financial Worker _____
Name Agency Telephone #

C. FAMILY SUPPORT SYSTEM (for purposes of this section, family means natural, adoptive or foster family)

Persons in the home: Indicate persons who live with the individual who will be able to provide care to the individual and what types of care they will perform.

Name	Care	Days/Hours at Home	Days/Hours will Care for Individual

If individual's family cannot perform any care, please attach an explanation.

Significant Others Outside the Home: Indicate informal caregivers such as relatives and friends who will provide care to the individual or assist the family in other ways.

Name	Age	Relationship	Care/Service	Days/Hours Assisting

Motivation

( ) Yes ( ) No ( ) ?	Does the individual's family fully understand the ramifications of caring for the individual at home? (i.e., medical personnel coming into home, unsightly medical equipment set up in the home, time demands, etc.)
( ) Yes ( ) No ( ) ?	If the individual is able, has he/she indicated a desire to live with his/her family?
( ) Yes ( ) No ( ) ?	Is the family capable both physically and emotionally to care for the individual?
( ) Yes ( ) No ( ) ?	Has the family indicated a desire to have the individual at home?
( ) Yes ( ) No ( ) ?	Has the family indicated that they want the individual home but will not provide any of the individual's care?
( ) Yes ( ) No ( ) ?	Has the family indicated that they want the individual home but will need help with the care?
( ) Yes ( ) No ( ) ?	Has the family indicated that they want the individual home and want to provide all the care for the individual?
( ) Yes ( ) No ( ) ?	Will the family need training in order to provide care for the individual?

Comments: (May use back of this page if space for additional comments is needed.)

Select one statement below which best describes the family and informal caregiver support system.

( ) Supports are strong and can be continued indefinitely
( ) Supports are weak and can be continued indefinitely
( ) Supports are strong but cannot be continued indefinitely
( ) Supports are weak and cannot be continued indefinitely
( ) No family or informal supports exist
( ) Don't know

Are there any special family, community, or cultural barriers or other special circumstances that are significant to caring for this individual in the community? Explain: (May use back of this page if space for additional explanation is needed.)

Team Recommends Community Care Services in

( ) Home of Parent/Spouse/Guardian ( ) Foster Home
( ) Other (specify) _____

Team Recommends individual receives services in a facility (institution)

( ) Acute care hospital ( ) Skilled nursing facility
( ) Intermediate (ICF) I ( ) ICF-II
( ) ICF/MR ( ) Other

Case Manager _____ Date _____
Signature

Appendix C

Date _____

COMMUNITY ALTERNATIVE CARE PROGRAM
PHYSICAL HOME ENVIRONMENT

IDENTIFYING INFORMATION

Individuals Name:_____ Birthdate: _____

I. GENERAL INFORMATION

Location:
( ) Urban
( ) Rural
( ) Other

Ownership:
( ) Own
( ) Rent
( ) Lives with relative or friend
( ) Government subsidized
( ) Other _____

Type of Home:
( ) Apartment
( ) Duplex
( ) Single family home
( ) Multi-family home
( ) Single story
( ) Two story
( ) Ground floor
( ) Isolated
( ) Other

II. EVALUATION GUIDELINES

A. Accessibility: The home should accommodate the individual's specific disability by allowing adequate room for medical equipment necessary for mobility and treatment. Adequate space should also be considered for the caregiver to enable access for proper care.

B. Space Requirements: The individual's room should have a minimum square footage area of 9 ft. by 9 ft. Any area in the home may be designated as the individual's room. Storage room for medical supplies equipment needs to be designated for immediate access (nite stand for frequently used items), proximal access (closet for less frequently used items), and bulk storage for long range supplies. The immediate access storage should have a hard surface finish and large storage areas should be free from dampness, have adequate temperature control and not contain toxic chemicals.

C. Electrical Requirements: When an individual requires heavy duty electrical equipment such as a respirator, a qualified electrician should evaluate the home's electrical capacity. In such situations the home must be supplied by a minimum of 100 amp. electrical service and have at least two separate 15 amp. branch circuits in the individual's room. An adequate number of outlets on each branch circuit need to be in the individual's room. If the main distribution panel utilizes fuses, spare fuses should be kept near the fuse box at all times.

D. Special Equipment: A telephone should be immediately accessible in or near the individual's room. If the individual is physically able, a calling device such as a bell or whistle should be at the individual's bedside. A battery operated light should be in the individual's room and a power failure alarm should be used on the electrical circuit which supplies life dependent equipment. Smoke alarms and fire extinguishers should be located on each level of the home.

E. General: The house should meet all local safety, sanitary, and building requirements.

II. PROBLEM AREAS:

Please indicate if there is a problem in a specific area regarding safety, adequacy, or accessibility and what solution is recommended.

Area	Safety	Adequacy	Accessibility	Solution
Individual's Room				
Living Area				
Eating Area				
Bathroom				
Entrances(s)				
Stairs				
Structural				
Storage				
Heating				
Cooling				
Water				
Electrical				
Windows				
Phone				

IV. SUMMARY OF HOME ENVIRONMENT MODIFICATION NECESSARY FOR SAFE DISCHARGE, ANTICIPATED COST FOR EACH, AND FUTURE CONSIDERATIONS:

Case Manager: _____ Title: _____

Telephone: _____

Appendix D

Date

COMMUNITY ALTERNATIVE CARE PROGRAM
INDIVIDUAL'S PROFILE

Individual's Name _____ Birthdate ____ _____ Age _____

Initial Evaluation for Discharge from Inpatient Hospital (If individual is not currently hospitalized - place a "X" in the box /__/ and go to page 2).

A. PERSONS PARTICIPATING IN PLANNING FOR HOME & COMMUNITY BASED CARE FOR INDIVIDUAL: Please list person's name, agency (if applicable) and telephone number.

This is a list of obligatory discharge planning team members

	Location/Agency	Telephone
Parent(s)/Spouse/Guardian		
Primary Caretaker (if different from above)		
Primary Physician		
Primary Nurse		
Medical Social Worker		
County Social Worker		
County Public Health Nurse		
Services for Children with Handicaps (for individuals under 21 years of age)		
Case Manager/Acting Case Manager		
Other (list discipline)		
Other		
Other		
Other		
Other		
Other		
Other		

_____/_____/_____
Date

COMMUNITY ALTERNATIVE CARE PROGRAM
INDIVIDUAL'S PROFILE

Individual's Name _____ Birthdate _____ Age __ ___

Current address: _____

/___/ Initial Evaluation for Individual Currently Residing in Community

/___/ Scheduled Re-evaluation of

/___/ Interrupted Change Care Plan

B. PERSONS PARTICIPATING IN PLANNING FOR HOME & COMMUNITY BASED CARE FOR INDIVIDUAL: Please list person's name, agency (if applicable) and telephone number. This is a list of obligatory community interdisciplinary team members.

Location/Agency Telephone

Parent(s)/Spouse/Guardian _____

Primary Caretaker (if different from above) _____

Primary Physician _____

County Social Worker _____ _____

County Public Health Nurse _____

Services for Children with Handicaps _____
(for individuals under 21 years of age)
Case Manager/Acting Case Manager _____

School Representative (when appropriate) _____

Other (list discipline) _____

Other _____

Other _____

Other _____

Other _____

Other _____

C. Health Condition

Individual's current diagnosis:

Physician's orders and current medications:

Individual's current overall health status:

How long will individual/family require ongoing home health services?

( ) Indefinitely ( ) 36 months ( ) 24 months ( ) 12 months
( ) less than 12 months

Can individual's condition be expected to improve?

( ) Yes ( ) No ( ) Somewhat

Will individual be able to learn to perform self-care?

( ) Yes ( ) No ( ) At an appropriate age ( ) Somewhat ( ) Unknown

D. Individual's Functional Needs/Activities of Daily Living

Select one answer only for each of the following 15 areas of functioning:

1. **BATHING**
   - ( ) Independent or appropriate to age
   - ( ) Supervision
   - ( ) Aid to get in or out of tub/shower
   - ( ) Aid in washing
   - ( ) Completely dependent

2. **DRESSING**
   - ( ) Independent or appropriate to age
   - ( ) Supervision
   - ( ) Aid of another person
   - ( ) Completely dependent

3. **EATING**
   - ( ) Independent or appropriate to age
   - ( ) Feeds self with help or supervision
   - ( ) Completely fed
   - ( ) Enteral feeding (gastrostomy)
   - ( ) Gavage fed
   - ( ) Total parenteral nutrition

4. **GROOMING (COMBING HAIR, BRUSHING TEETH, ETC.)**
   - ( ) Independent or appropriate to age
   - ( ) Supervision
   - ( ) Some assistance needed
   - ( ) Completely dependent

5. **TOILETING**
   - ( ) Independent or appropriate to age
   - ( ) Needs help to toilet, no incontinence
   - ( ) Occasional accident
   - ( ) Incontinent bladder
   - ( ) Incontinent bowel
   - ( ) Ostomy appliance (bowel or bladder)
   - ( ) Urinary catherization (intermittent or indwelling)
   - ( ) Incontinent bowel and bladder (not trained)

6. **BED MOBILITY**
   - ( ) Independent or appropriate to age
   - ( ) Occasional help to sit up
   - ( ) Always helped to sit up
   - ( ) Must be turned or positioned

7. **TRANSFERRING**
   - ( ) Independent or appropriate to age
   - ( ) Needs guidance only
   - ( ) Aid of one person
   - ( ) Needs two persons or mechanical device
   - ( ) Bedfast

8. **WALKING**
   - ( ) Independent or appropriate to age
   - ( ) Independent with a device
   - ( ) Aid of one person
   - ( ) Aid of two persons
   - ( ) Does not walk

9. **COMMUNICATION**
   - ( ) Normal speech or appropriate to age
   - ( ) Speech impairment but can be understood
   - ( ) Alternative communication/uses gestures/written/sign language
   - ( ) Inappropriate content, garbled sounds
   - ( ) Refuses or unable to communicate in any form
   - ( ) Does not understand English/needs language interpreter

10. **HEARING**
    - ( ) Normal
    - ( ) Normal with hearing aid
    - ( ) Impairment
    - ( ) Partial impairment - not correctable
    - ( ) Severely impaired - total impairment not correctable
    - ( ) Unknown

11. **VISION**
    - ( ) No impairment
    - ( ) Impairment corrected with glasses
    - ( ) Incorrectable impairment
    - ( ) Blind
    - ( ) Unknown

12. **ORIENTATION**
    - ( ) Oriented: alert and recognizes caregiver
    - ( ) Partial/intermittent periods of disorientation
    - ( ) Totally disoriented; does not recognize caregiver
    - ( ) Comatose

13. **RESPIRATION**
    - ( ) Normal/unassisted
    - ( ) Oxygen supplemented
    - ( ) Ventilator assisted

14. MOBILITY
    ( ) Independent or appropriate to age
    ( ) Does not need help of another person or special aid but has trouble getting around freely
    ( ) Needs help with special aid such as another person, cane or wheelchair in getting around inside or outside the house
    ( ) Housebound most or all of time
    ( ) Bedbound most or all of time

15. BEHAVIOR
    ( ) No problem
    ( ) Minor problem: irritable and uncooperative occasionally
    ( ) Moderate problem: demanding and obnoxious
    ( ) Major problem: assaultive/injurious to self and/or others

E. INDIVIDUAL'S SCHOOL PLACEMENT/DEVELOPMENTAL LEVEL

Does not apply to individual's over 22 years of age.

Has individual been tested? ( ) Yes ( ) No

If yes, please specify test(s) given and results:

If no, please specify why individual was not tested:

Educational Plan. Please check only one answer:

( ) No program available/or no program needed

( ) Preschool program or DAC

( ) Regular class placement. Specify grade _____

( ) Special Education. Please submit copy of Individual Education Plan (IEP)

( ) Other (specify) _____

Comments/Problems with educational plan:

F. Service Needs

Please check the services which the individual is currently receiving, and those which are needed now. If services are added or deleted in the "needed" column, please explain why. If you are able, anticipate future needs which the individual or family may have. This list is meant to identify services that are needed. Some of these services are not reimbursable through Medical Assistance or the waiver.

	CURRENTLY RECEIVING	NEEDED NOW	FUTURE NEEDS	COMMENTS
Dental				
Primary Medical Care				
Specialized Medical Services				
Nursing Services				
Public Health Nursing Services				
Physical Therapy by PT or Aide				
Occupational Therapy by OTR or Aide				
Language or Speech Therapy				
Respiratory Therapy by RT or Aide				
Nutritional Therapy				
Home Health Aide				
Homemaker Services				
Mental Health Services				
Training for Family Members				
Special Recreation				
Day Care				
Respite Care				
Transportation				
Environmental Modification				
School Evaluation and Placement				
Utility				

Explanation: (Use reverse side if an explanation is needed)

Case Manager _____ Date _____

ATTACHMENT VI

DOCUMENTATION OF FISCAL YEAR EXPENDITURES

Minnesota assures HCFA that there will be a cost savings under this model waiver request. Each individual will be accepted under this waiver only if a cost savings can be shown. Furthermore, the state agency will attempt to recover any third party liability if applicable. The greatest savings will be achieved by allowing home placement and care of individuals currently confined to in-patient hospital settings. This program is focusing its efforts on diverting individuals from in-patient hospitalization. These individuals require inpatient hospital care or SNF care but remain in an inpatient hospital setting as no SNF will care for them.

Cost estimates for the next three years have been projected according to the formula in 42 CFR 441.303 (d). The figures have been based on some real cases of individuals currently hospitalized in Minnesota. The projections demonstrate that these individuals are hospitalized in lieu of SNF level of care.

HOME CARE COSTS

Home and Community-Based Waivered Services

The following are estimates of costs and units of service with the exception of respite care and environmental modifications which is a maximum number of units.

Service	Unit of Service	Cost Year 1	Cost Year 2	Cost Year 3
Case Mgmt. (48 visits)	$ 50.00 per visit	$ 2400.00	$ 2592.00	$ 2799.00
*Respite Care (30 days)	$200.00 per day	$ 6000.00	$ 6480.00	$ 6998.00
Environmental Modifications to the Home	$3000.00 maximum for each recipient in any one year of the waiver and $500.00 each for the other two years of the waiver	$ 3000.00	$ 500.00	$ 500.00
Family Counseling & Training (10 visits for year 1 and 4 visits in each of the next two years)	$ 50.00 per visit	$ 500.00	$ 216.00	$ 233.00
Homemaker (2 hours per day 5 days per week)	$ 10.00 per day	$ 2600.00	$ 2808.00	$ 3033.00

STATE PLAN EXTENDED SERVICES:

Service	Unit of Service	Cost Year 1	Cost Year 2	Cost Year 3
Nursing Services (16 hours per day - 30 days for respite care)	$ 240.00 per day	$80,400.00	$86,832.00	$93,779.00
Physician Visits (24 visits)	$ 66.00 per visit	$ 1,584.00	$ 1,711.00	$ 1,848.00
Laboratory Work	$ 8.00 per month	$ 96.00	$ 104.00	$ 112.00

**Medications	$ 134.00 per month	$ 1,608.00	$ 1,737.00	$ 1,876.00
Equipment & Supplies	$1980.00 per month	$23,760.00	$25,661.00	$27,714.00

*The cost of respite care at $200.00 per day can only be made available through a waiver from HCFA under current Minnesota state law and rules. Providers will accept individuals with chronic illnesses on a short-term basis for $200.00 per day but not permanently at their regular per diem rate.

**The estimates for equipment, supplies, medications, and laboratory work were based on projections developed for actual individuals. A hospital-based physician in conjunction with a medical supplier did the projections.

Therapy Services

Occupational Therapy (48 visits per year)	$ 26.00 per visit	$ 1,248.00	$ 1,348.00	$ 1,456.00
Physical Therapy (48 visits per year)	$ 26.00 per visit	$ 1,248.00	$ 1,348.00	$ 1,456.00
Speech Therapy (48 visits per year)	$ 26.00 per visit	$ 1,248.00	$ 1,348.00	$ 1,456.00
Nutrition (12 visits per year)	$ 22.00 per visit	$ 264.00	$ 285.00	$ 308.00
Transportation (3 hours per week)	$ 15.00 per hour	$ 2,340.00 $128,296.00	$ 2,527.00 *$135,497.00	$ 2,729.00 **$146,297.00
Foster Care	$500.00 per month	$ 6,000.00	$ 6,480.00	$ 6,998.00

If an individual is placed in foster care the costs of respite care are not covered under this waiver. Therefore, the cost of D will be the same whether the individual is at home or in foster care.

*In second year projection actual figure for D will be $136,909.00 which will include an additional $2,500 for environmental modifications and family counseling and support for an additional $324.00 for 16 clients starting in service in year 2.

**In third year projection actual figure for D will be $147,323.00 which will include an additional $2,500 and an additional $349.50 for the same services for an additional 18 clients starting service in year 3.

First Year Projection
4/85 - 3/86

A = Total SNF population 30,283

B = $10,734.00

A X B = $325,057,722.00

C = 16
D = $128,296.00

C X D = $2,052,736.00

		Definitions
F1 = 30,283		F1 = Total SNF population
F2 = 16		F2 = Hospital in lieu of SNF
G1 = $ 10,734.00 X $30,283	= $325,057,722.00	G1 = SNF rate
G2 = $366,741.05 X 16	= $ 5,867,856.00	G2 = Hospital rate in lieu of
	$330,925,578.00	SNF rate

H X I = O

$$\frac{(A \times B) + (C \times D)}{F + H} \leq \frac{(F \times G) + (H \times I)}{F + H}$$

$$\frac{\$327,110,458.00}{30,299} \leq \frac{\$330,925,578.00}{30,299}$$

$$\$\ 10,797.00 \leq \$\ 10,923.00$$

Minnesota does not currently provide services to chronically ill individuals in non-institutional settings as described in H, therefore, H = O and H x I = O.

Second Year Projection
4/86 - 3/87

(An 8% increase was projected for all costs with the exception of hospital costs which have been increasing at a rate of 14%.)

A = 31,191

B = $11,592

A x B = $361,566,072.00

C = 32
D = $136,909.00
C x D = $4,381,088.00

F1 = 31,191
F2 = 32

G1 = $ 11,592.00 x 31,191 = $361,566,072.00
G2 = 418,084.80 x 32 = $ 13,378,688.00
$374,944,760.00

H x I = 0

$$\frac{365,947,160.00}{31,223} \leq \frac{374,944,760.00}{31,223}$$

$$\$11,720.44 \leq \$12,009.00$$

Third Year Projection
4/87 - 3/88

(An 8% increase was projected for all costs with the exception of hospital costs, G2, which have been increasing at a rate of 14%.)

A = 32,127

B = $12,519

A x B = $402,197,913.00

C = 50

D = $147,323.00

C x D = $7,366,150.00

F1 = $32,127
F2 = 50

G1 = $ 12,519.00 x 32,197 = $402,197,913.00
G2 = $476,616.67 x 50 = $ 23,830,834.00
$426,028,747.00

$$\frac{409,564,063.00}{32,177} \leq \frac{426,028,747.00}{32,177}$$

$12,728.47 ≤ $13,240.00

Attachment B

RECEIVED
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ADMINISTRATIVE
HEARINGS

MINNESOTA COUNTIES
with
CURRENT CAC RECIPIENTS

July 1990

Anoka County
Blue Earth County
Brown County
Carver County
Chippewa County
Dakota County
Hennepin County
Lyon County
Mower County
Koochiching County
Polk County
Ramsey County
St. Louis County
Stearns County
Washington County
Watonwan County
Winona County

9 other counties have had CAC recipients previously.

Attachment C

COMMUNITY ALTERNATIVE CARE
FOR
CHRONICALLY ILL INDIVIDUALS

RULE ADVISORY COMMITTEE MEMBERS

Jim Abts, Ramsey County Human Services Department

Richard Backman, Washington County Social Services

Barbara Balik, R.N., M.S., Clinical Director, Minneapolis Children's Medical Center

Becky Bedore, Home Care, Minneapolis Children's Medical Center

Stan Kaitfors, St. Louis County Social Services Department

Mary Lou Christensen, Ramsey County Nursing Service

Gary Fahnhorst, Sherburne County Social Services

Judy Giel, 9631 Penn Avenue South, Bloomington, MN 55431

Tim Jeffreys, Stearns County Social Service Center

Sue Lamoureux, St. Paul Children's Hospital

Georgianna Larson, PATHFINDER, Minneapolis, MN 55416

Ruth Ellen Luehr, R.N., M.S., School Health Services Specialist, Minnesota Department of Education

Todd Monson, Hennepin County Community Health Department

Gretchen Musicant, Minnesota Nurses Association

Virginia Naros, Naros and Associates Pediatric Nursing Resources

Lori Wedeking, Minnesota Department of Health