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VARIOUS DISABILITY-RELATED PROVISIONS, 2001 LEGISLATION

By: Anne L. Henry
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OVERVIEW

The 2001 Legislative Session and Special Session were marked by a huge budget surplus which declined a bit over the course of the Session due to economic conditions. **One of the most noteworthy developments during the legislative session involved a decision in late March by the Department of Human Services (DHS) to follow a 1999 law regarding the waiting list for home and community waiver services for persons with developmental disabilities.** The DHS decision, made after several legislative hearings on unspent waiver funds, will result in thousands of persons from the waiting list being able to obtain services. The DHS decision should result in spending a good portion of the \$66 million for the next biennium which had been designated as surplus prior to the Administration's decision to encourage counties to use the resources as required by 1999 legislation.

Disability-Related Provisions Of The Omnibus Spending Bill For Health And Human Services, Chapter 9, First Special Session 2001.

1. Medical Assistance Income Standard for Persons Who are Elderly or Disabled, Article 2, Sections 16, 17, 21 and 24.
 - a. For persons whose Social Security or other income is at or below \$716 per month (100% of the Federal Poverty Guidelines (FPG)), the Legislature provided an increase from the current income standard of \$482 per month to \$716, 100% FPG.
 - b. For persons with Social Security or other income over 100% FPG (i.e. \$717 per month or higher), the Legislature changed the standard only to 70% FPG on July 1, 2001 and 75% FPG on July 1, 2002. Unfortunately, persons who

are elderly or disabled with unearned income (those with earnings can use MA-EPD eligibility) over 100% FPG will have to continue to pay a spend down to \$502 per month (70% FPG) beginning July 1, 2001, 75% FPG beginning July 1, 2002.

- c. The cost of the increase in the income standard was offset by savings in Minnesota's state-funded Prescription Drug Program (PDP). Medical Assistance is funded with 51% federal funds and 49% state funds, whereas the PDP program is funded entirely by state dollars. As the MA Income Standard rises, more persons will choose MA rather than PDP.

These changes will mean that 9,000 persons who are eligible for Medical Assistance due to age or disability will be relieved of a spend down obligation on July 1, 2001. A spend down is much like a deductible payment in which medical costs must be incurred to a certain dollar amount before health coverage (MA in this case) will pay additional medical costs. The medically needy group (those with unearned income over \$716 per month) of 4,000 persons on Medical Assistance and 1,400 persons on General Assistance Medical Care will gradually be allowed to keep more of their income to live on rather than having to spend it on medical costs down to \$482 per month.

2. Medical Assistance for Employed Persons with Disabilities (MA-EPD) Premium Increase, Article 2, Section 28.

A premium increase for persons with disabilities who need Medical Assistance and have earnings will likely affect nearly everyone using the MA-EPD eligibility option. The premium schedule interacts with the MA income standard increase in that persons with **earned and unearned income below 100% FPG (\$716/month)** will no longer be required to spend down to be eligible for Medical Assistance. Therefore, unless these persons have assets over \$3,000 or a spouse, they will not need the MA-EPD option.

Individuals with earned and unearned **incomes over 100% FPG**, will be required to pay a premium on a sliding scale basis beginning at 1% of total income at 100% of FPG and rising to 7.5% of total income for those at or above 300% FPG. This means that approximately 5,000 persons using the MA-EPD eligibility option will be required to pay a premium beginning November 1, 2001. DHS is required to provide MA-EPD participants with a general notice that a premium change will become

effective November 1, 2001. Several disability groups as well as DHS are working to provide the sliding fee scale premium information on their web sites by the fall.

The premium for persons at 100% FPG will be \$7 per month. Those with 300% FPG in earned and unearned income (\$2,148 per month) will be required to pay \$161 per month beginning September 1, 2001. For those with earnings above \$2,148 per month, 7.5% of total gross income will be required as a premium.

3. Medical Assistance for Employed Persons with Disabilities (MA-EPD), Asset and Income Protection During Illness or Job Loss, Article 2, Sections 19 and 28, amends Minn. Stat. § 256B.056, Subd. 3.

After at least one month of MA-EPD enrollment, a person who is temporarily unable to work due to a medical condition verified by a physician, may retain eligibility for up to four calendar months. This provision means that an individual with disabilities eligible for MA-EPD will not have to spend down to the excess income standard if their income is above 100% of the Federal Poverty Guidelines (FPG) for up to four months while recovering from an illness or injury. The individual will also be able to retain their assets up to the standards of MA-EPD (up to \$20,000, etc.) rather than the regular Medical Assistance asset limits (\$3,000 for an individual). This provision is effective **November** 1, 2001.

Another provision allows MA-EPD participants who lose their jobs to retain assets accumulated while eligible for MA-EPD for up to 12 months. The asset retention provision is available for any reason, including layoff, job change or extended illness, while the income provision above is only available if lack of earnings is due to a medical condition. **THIS PROVISION ONLY BECOMES EFFECTIVE UPON FEDERAL APPROVAL, SO THE EFFECTIVE DATE IS UNCERTAIN.**

4. Expansion of the Prescription Drug Program (PDP) for Persons with Disabilities and the Elderly, Article 2, Section 7 and 8.

The state-funded Prescription Drug Program (PDP) eligibility level for persons with disabilities was changed from 100% of the Federal Poverty Guidelines (FPG) to 120% FPG beginning July 1, 2002. This means that persons on Medicare with income up to 120% FPG (\$859/month) will be eligible for prescription drug coverage by paying a monthly premium of \$35.

Unfortunately, the Legislature failed to treat persons on Medicare under 65 similarly to persons over 65. Persons over 65 are eligible for the PDP up to 135% FPG beginning January 1, 2002.

5. Child Support Disregard for Children with Disabilities Eligible for MA Under the TEFRA Option, Article 2, Section 16.

Children who have child support payments or Social Security Survivor or Disability benefits paid by parents or through the parents' Social Security eligibility will no longer have those funds subject to a spend down in order to be eligible for Medical Assistance under the TEFRA and Home and Community Waiver Options. This change affects a small number of families. Two-parent families whose children are eligible through the TEFRA or Home and Community Waiver Options must pay a parental fee, but are not subject to a spend down.

Because child support has been treated as income to the child, children had to spend down the child support or Social Security benefits in order to obtain Medical Assistance services through the TEFRA or Home and Community Waiver Options.

This very unfair provision has been changed and these children and their parents will now be able to use child support or Social Security benefits to pay basic living expenses rather than a spend down for health care coverage. This provision is effective upon federal approval which should be readily forthcoming given recent clarifications in federal rules and policy.

6. Provider Cost-of-Living Increase, Article 5, Section 37.

Health and Human Services providers in long-term care and community support services received a 3% cost-of-living increase for each year of the biennium. Intermediate Care Facilities for persons with mental retardation or a related condition (ICF-MR) and Day Training and Habilitation (DT&H) programs reimbursed through Medical Assistance were given a 3.5% increase each year.

7. Consumer Support Grant (CSG) Program, Article 3, Sections 9-15.

The Consumer Support Grant program is a state-funded program which allows persons to "trade in" their MA home care or other community support services funded by Medical Assistance, and obtain a cash grant equal to the amount of state funds in their Medical Assistance services. Currently, this means that persons receive 49% of their Medical Assistance home care.

As part of their biennial budget, DHS proposed major changes to the state-funded Consumer Support Grant program and estimated millions of dollars in savings if

those changes were adopted by the Legislature. The DHS Consumer Support Grant proposal was amended in several significant ways during the session. Projected savings from changing the CSG program were used to fund other initiatives in the Health and Human Services budget, but the program will remain available to those who need it under the following circumstances:

- a. **Rather than capping the program, new persons will be eligible based upon the percentage of statewide average utilization of home care applied to their individual home care rating category (a category based on the person's disability-related needs) authorization of care.** For example, the statewide average utilization is now about 78%. This percentage is then applied to the average hours of care authorized for the individual's home care rating category. This negotiated change in the DHS proposal means that funding will be more sensitive to the needs of persons with disabilities, directing more resources towards those with higher needs.
 - b. **Two-hundred "exception grants"** will be available for distribution to persons with exceptional needs as determined by the county. These exception grants will be provided on a first-come first-serve basis by DHS based upon the date of county request. The exception grants will be limited to the average authorization provided for persons in each home care rating category, but not reduced by the statewide average utilization percentage as in number (a.) above. The 200 exception grants includes those individuals who are "grandfathered-in" at current grant amounts described in (c.).
 - c. **All persons currently using consumer support grants will be able to continue to use the amount of their grant on July 1, 2001.** As these individuals leave the CSG program, those grants will be available for distribution as "exception grants" in number (b.) above.
 - d. **The CSG program is required to be offered to all Minnesotans whether or not their counties choose to participate beginning July 1, 2002.**
8. Child Maltreatment Review Panel, Chapter 9, Article 11, Section 3.

A Child Maltreatment Review Panel allowing persons to request a review of decisions by DHS or DCFL on child maltreatment reports was funded. The Child Maltreatment Review Panel is patterned after the Vulnerable Adult Review Panel established in 1999.

9. Autism Therapies, Article 2, Section 31, Minn. Stat. § 256B.0625, Subd. 5a.

A new service entitled “Intensive Early Intervention Behavior Therapy Services for Children With Autism Spectrum Disorders” has been added to the list of Medical Assistance covered services as of January 1, 2003.

The provision has detailed eligibility requirements including IQ and age criteria, along with continuation criteria after six months of treatment. In his message on the signing of the Health and Human Services Omnibus bill, Governor Ventura expressed fiscal and policy concerns with this section. He stated that he expects the Legislature to work with DHS “to make improvements” next session to address the narrow focus in both diagnosis and treatment strategies.

10. Personal Care Assistant (PCA) Services, Chapter 9, Article 3, Section 29.

Several important changes occurred effective July 1, 2001 for personal care assistant services:

- a. Language **limiting** PCA (or Private Duty Nursing) services outside the home to circumstances on which “the recipient’s health and safety would be jeopardized” has been **deleted**. Article 3, Sections 16 and 17.
- b. **A legal guardian is allowed to provide personal care services if granted a hardship waiver.** This option is allowed would have been eliminated on July 1, 2001, but the sunset date was removed so that non-corporate legal guardians of adults can continue to be paid as PCAs. Article 3, Section 17.
- c. **Adds instrumental activities of daily living as allowed PCA activities.** These additional activities will not result in any added hours of PCA service under the assessment. Instrumental activities of daily living include “meal prep planning and preparation, managing finances, shopping for food, clothing and other essential items, performing essential household chores, communication by telephone and other media, and getting around and participating in the community.” Article 3, Section 29.
- d. **All services provided by a PCA must relate to activities of daily living, health-related functions, behavior intervention and redirection.** Article 3, Section 31.

- e. **Health-related tasks performed by a PCA must be under the supervision of either a qualified professional or a physician. Nurse supervision is no longer required.** Article 3, Section 31.
 - f. **Shared PCA services can be supervised by the recipient or responsible party or a qualified professional.** Article 3, Section 34.
 - g. **The fiscal agent option for PCA services is renamed the “Fiscal Intermediary Option.”** Article 3, Sections 30 and 35.
11. MA Home Care Changes to Private Duty Nursing (PDN), Chapter 9, Article 3, Sections 29 and 32.

A number of changes have been made to the MA home care statute which affect nursing supervision and private duty nursing:

- a. Complex and regular private duty nursing care are defined and effective July 1, 2001. Complex care is private duty nursing provided to recipients who are ventilator dependent or would meet criteria for inpatient hospital ICU level of care and regular PDN care is provided to all others eligible for nursing services. These definitions apply to both RNs and LPNs. Article 9, Section 29.
 - b. Private Duty Nurse rates increased July 1, 2001 an average of 8.5% in addition to the 3% provider COLA described in #6.
 - c. Up to nine skilled nurse visits are now available without prior authorization (previous limit was five visits). Also, DHS or the public health nurse may authorize up to two skilled nurse visits per day. Article 3, Section 32.
12. Private Duty Nursing Services Provided by Parents, Spouses, or Legal Guardians, Hardship Criteria, Chapter 9, Article 3, Section 40. Minn. Stat. § 256B.0627, Subd. 16.

A new section of law allows **payment for “extraordinary services” that require “specialized nursing skill” and are provided by nurses who are parents of minor children, spouses or legal guardians under hardship conditions** including:

- a. The services are not legally required to be provided by parents, spouses or legal guardians,
 - b. Services are necessary to prevent hospitalization of the recipient, and
 - c. The recipient is eligible for MA home care or waived services, and hardship criteria are met, including that the parent, spouse or legal guardian resigns from a job to provide nursing, goes from full time to part time, takes a leave without pay, or because of labor conditions and special needs the individual is unable to obtain needed private duty nursing services.
 - d. The family member nurse may not be paid for more than 50% of the total approved nursing hours, or 8 hours a day whichever is less up to a maximum of 40 hours per week.
 - e. Criminal background checks are required.
13. Changes to Pre-admission Screening for Individuals Under 65 Years of Age Considered for Nursing Home Placement, Chapter 9, Article 3, Section 42, Minn. Stat. § 256B.0911, Subd. 4a.
- a. **Changes will require that individuals under 65 years of age admitted to nursing facilities must be screened prior to admission.** If an individual under 65 is admitted to an nursing facility with only a telephone screening, they must receive a face-to-face assessment within 20 working days.
 - b. **If the individual is under 21 years of age, the Commissioner must approve the admission before the individual is admitted to a nursing facility.**
 - c. If a person is admitted on an emergency basis, the county must be notified on the next working day and the face-to-face assessment must occur within 20 working days.
 - d. At the face-to-face assessment, information about home and community-based options must be provided to the individual.
 - e. If the individual chooses home and community-based services, a relocation plan must be completed within 20 working days of the visit.

- f. Individuals living in nursing homes who are under 65 years of age must receive a face-to-face assessment with alternatives at least once every 12 months unless the person indicates in writing that they do not want annual assessments, in which case a face-to-face assessment must occur once every 36 months.
 - g. The Commissioner is allowed to pay county agencies for the face-to-face assessments for individuals who are under 65 years of age, eligible for Medical Assistance and considering nursing home placement.
14. Changes to Home and Community Waiver for Persons with Traumatic Brain Injury (TBI), Article 3, Section 67, Minn. Stat. § 256B.49, Subd. 20.

DHS is required to amend the TBI waiver to include persons with **acquired or degenerative disease diagnosis where cognitive impairment is present**. Multiple Sclerosis is given as an example of one of the conditions to be newly covered under the TBI waiver. DHS will have to request the change, so the effect date is uncertain.

15. Targeted Case Management for Persons Under 65 in Nursing Homes and MA Home Care Recipients, Chapter 9, Article 3, Sections 20-28, and for Vulnerable Adults and Persons with Developmental Disabilities, Chapter 2, Sections 39 and 44.

Three new types of targeted case management have been added to the Medical Assistance benefit set:

- a. **Targeted case management for persons under 65 in nursing homes who want to relocate to community services.** This type of case management can only be provided by a county or an entity under contract with the county unless the county does not provide a case manager within 20 days after a written request from a nursing home resident. If a county fails to provide a case manager to a person in a nursing home, a private agency can provide "relocation targeted case management." Relocation targeted case management is effective July 1, 2001 and is available for only six months for an individual to move out of a nursing home.
- b. **Home care targeted case management which can be provided by a private or a public entity based upon the person's choice.** Home care targeted case management is ongoing whereas targeted case management for

persons in nursing homes is only provided for six months while the person moves out of the nursing home and into community services. Home care targeted case management only becomes effective January 1, 2003 (Section 23).

- c. **Targeted case management for vulnerable adults and persons with developmental disabilities who are not receiving waiver funding.** This third type of case management for vulnerable adults is funded with county funds used to match federal Medicaid funds. The new type of case management and funding is effective January 1, 2002 (Article 2, Sections 39 and 44).
16. Reorganization of Disability Waivers, CADI, CAC, TBI, Chapter 9, Article 3, Sections 58-66, Minn. Stat. § 256B.49, Subd. 11-19.
- a. **The DHS proposal to reorganize the three disability waivers into more streamlined waivers was adopted** as part of the Omnibus Health and Human Services bill. The purpose of the new “disability waivers” is to provide community care to persons under 65 years of age who need the level of care provided in the nursing home or a hospital. The services are to be provided to support persons with disabilities in integrated settings, to expand the availability of services for persons eligible for Medical Assistance, to promote cost effective options to institutional care and to obtain federal financial participation.
 - b. **Case Management.** The new disability waiver provisions require that:
 - 1 individuals are offered an informed choice between institutional care and community-based care,
 - 2 that persons receive case management including assessment,
 - 3 development of an individual service plan,
 - 4 assistance with obtaining service providers and
 - 5 access to service,
 - 6 coordination,

- 7 evaluation,
 - 8 annual reviews and
 - 9 information on an individual's right to services including time lines
and
 - 10 appeals.
 - 11 Case management services may be delegated to another individual
provided there is oversight by the case manager.
 - 12 Assessment and reassessment provisions are contained in Minn. Stat.
§ 256B.49, Subd. 14, individual service plan requirements are found
in Subdivision 15, services and supports in Subdivision 16 and cost-
related provisions in Subdivision 17.
- c. **The legislation requires a statewide average payment amount shall be implemented January 1, 2002 with an aggregate, needs based method for allocating funds.** This new aggregate method of funding should better serve persons with higher needs than the current individual cap based on an average nursing home or hospital payment.
 - d. **Consumer-directed community supports are required to be offered as an option to all eligible persons by January 1, 2002.**
 - e. By January 1, 2003, the Commissioner is required to simplify and improve access to services through the establishment of a **common service menu for all persons using the disability waivers.**
 - f. Until the new payment system is in place January 1, 2002, the Commissioner can approve higher waiver funding based upon the extraordinary needs of the individual beginning July 1, 2001 (Section 64). The higher amount must be necessary to prevent institutionalization or to get the person out of a facility.
17. Medical Assistance Managed Care Will Remain Voluntary for Persons with Disabilities Under 65 Years of Age, Article 2, Section 52, Minn. Stat. § 256B.69, Subd 23.

Language which eliminated the requirement that managed care remain a voluntary option for persons with disabilities under 65 was changed by the Legislature. The voluntary status of managed care for persons under 65 eligible for Medical Assistance now has no expiration date so that any managed care will have to remain voluntary.

18. New Requirements When Same Agency Provides Both Day and Residential Services, Chapter 9, Article 3, Section 46, Minn. Stat. § 256B.092, Subd. 5.

New language requires that an individual needing both day and residential services should have two different agencies provide these services. However, the same agency may provide both day and residential services if the person and their legal representative are offered a choice of providers and agree in writing to both day and residential services from the same provider. The person's Individual Service Plan must describe how the person will be protected and in contact with individuals not employed by the agency.

19. Medicaid Funding for Day Programs, Chapter 9, Article 13, Section 22.

The commissioner of human services is required to request a day services home and community waiver to allow Medicaid reimbursement for supported employment and community inclusion day training and habilitation services (DT & H services). The provision will require counties to pay the non-federal share to match federal Medicaid funds. Currently, counties pay the full cost for about 1/4 of adults with developmental disabilities who participate in DT & H services. The section is effective the later of July 1, 2003 or two years after federal approval of the waiver.

20. Public Guardianship Changes, Chapter 9, Article 13, Sections 7-13.

Several significant changes were made to the Public Guardianship Statute including a new requirement that a guardianship service provider meet the ethical and best practice standards of the National Guardianship Association. Although counties are not considered guardianship service providers, this new definition should be helpful in trying to get counties to contract with qualified private entities to perform guardianship duties.

Language clarifying that a county guardian does not have to be found inadequate or unfit to be removed in favor of a family member was adopted. Family members must still be found to be able to act in the person's best interest.

Funding of \$250,000 per year for two years was provided to assist counties to transfer persons from public to private guardianship.

21. Patient Protection Act, Chapter 9, Article 16.

A number of patient protection provisions were adopted after changes were made to meet Governor Ventura's objections to including state employee health plans in the access to specialty care provision. The Act provides for 1) recommendation to the Legislature on health coverage during participation in a clinical trial, due January 15, 2002; 2) continuity of care improvements for some medical conditions; and 3) access to specialty care, including requiring a process for obtaining a "standing referral," conditions for a mandatory standing referral and coordination of services by a specialist.

22. Minnesota Family Investment Plan (MFIP) Extensions for Parents Caring for Children or Adults with Disabilities, Chapter 9, Article 10.

a. Participants eligible for extension of the 60-month cash assistance limit include those who:

- 1 are ill or incapacitated,
- 2 whose presence in the home is required to care for a family member whose illness is expected to last more than 30 days, or will qualify for MFIP benefits beyond 60 months, or
- 3 are caregivers for a child or adult who qualifies for home care or as a person with severe emotional disturbance or serious and persistent mental illness.

b. In addition, parents who were granted extensions can qualify for employment and training services for the number of months spent in exempt status.

23. **DHS Licensing Staff Increases, Article 17, Section 2, Subd. 1(c).**

A DHS budget proposal to increase licensors to improve service was funded for over \$2 million for 14 new staff. The appropriation requires DHS to meet the promised outcomes of:

- a. reduced average length of investigation of licensing complaints to 75 days;
- b. completion of all licensing reviews with one or two years as required in statute; and

- c. completion of negative licensing action decisions within 45 days of county recommendations.

Other Chapters

1. Criminal Background Check Every Three Years Required for Non-Family Private Guardians for Two or More Persons, Chapter 163, Amends Minn. Stat. § 254A and Minn. Stat. § 525.539.
2. The Council on Disability which was to sunset as an agency this July, is extended to July 1, 2003.
3. State Waiver of Immunity for Violations of Federal Rights Statutes, Chapter 159.

The Legislature decided to allow current, former and prospective state employees to sue the state for violations of the Americans with Disabilities Act, the Age Discrimination in Employment Act, the Fair Labor Standards Act and the Family Medical Leave Act. The United States Supreme Court in the *Garret* case has recently held that under the Eleventh Amendment, a state is immune from damage actions in federal court unless it waives its immunity. This Act clears the way for such lawsuits.