# SENATE
## STATE OF MINNESOTA
## NINETY-SECOND SESSION

# S.F. No. 3816

**(SENATE AUTHORS: ABELER, Hoffman and Newton)**

| DATE | D-PG | OFFICIAL STATUS |
|---|---|---|
| 03/09/2022 | 5250 | Introduction and first reading<br>Referred to Human Services Reform Finance and Policy |

A bill for an act

relating to human services; recodifying long-term care consultation services; amending Minnesota Statutes 2020, sections 144.0724, subdivision 11; 256.975, subdivisions 7a, 7b, 7c, 7d; 256B.051, subdivision 4; 256B.0646; 256B.0659, subdivision 3a; 256B.0911, subdivisions 1, 3c, 3d, 3e, by adding subdivisions; 256B.0913, subdivision 4; 256B.092, subdivisions 1a, 1b; 256B.0922, subdivision 1; 256B.49, subdivisions 12, 13; 256S.02, subdivisions 15, 20; 256S.06, subdivisions 1, 2; 256S.10, subdivision 2; Minnesota Statutes 2021 Supplement, sections 144.0724, subdivisions 4, 12; 256B.49, subdivision 14; 256B.85, subdivisions 2, 5; 256S.05, subdivision 2; repealing Minnesota Statutes 2020, section 256B.0911, subdivisions 2b, 2c, 3, 3b, 3g, 4d, 4e, 5, 6; Minnesota Statutes 2021 Supplement, section 256B.0911, subdivisions 1a, 3a, 3f.

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

## ARTICLE 1

## LONG-TERM CARE CONSULTATION SERVICES RECODIFICATION

Section 1. Minnesota Statutes 2020, section 256B.0911, subdivision 1, is amended to read:

Subdivision 1. **Purpose and goal.** (a) The purpose of long-term care consultation services is to assist persons with long-term or chronic care needs in making care decisions and selecting support and service options that meet their needs and reflect their preferences. The availability of, and access to, information and other types of assistance, including long-term care consultation assessment and ~~community~~ support planning, is also intended to prevent or delay institutional placements and to provide access to transition assistance after placement. Further, the goal of long-term care consultation services is to contain costs associated with unnecessary institutional admissions. Long-term care consultation services must be available to any person regardless of public program eligibility.

(b) The commissioner of human services shall seek to maximize use of available federal and state funds and establish the broadest program possible within the funding available.

(c) Long-term care consultation services must be coordinated with long-term care options counseling ~~provided under subdivision 4d, section 256.975, subdivisions 7 to 7c, and section 256.01, subdivision 24~~, long-term care options counseling for assisted living, the Disability Hub, and preadmission screening.

(d) ~~The~~ A lead agency providing long-term care consultation services shall encourage the use of volunteers from families, religious organizations, social clubs, and similar civic and service organizations to provide community-based services.

Sec. 2. Minnesota Statutes 2020, section 256B.0911, subdivision 3c, is amended to read:

Subd. 3c. **~~Consultation~~ Long-term care options counseling for ~~housing with services~~ assisted living.** (a) The purpose of long-term care ~~consultation for registered housing with services~~ options counseling for assisted living is to support persons with current or anticipated long-term care needs in making informed choices among options that include the most cost-effective and least restrictive settings. Prospective residents maintain the right to choose ~~housing with services or~~ assisted living if that option is their preference.

(b) ~~Registered housing with services establishments~~ Licensed assisted living facilities shall inform each prospective resident or the prospective resident's designated or legal representative of the availability of long-term care ~~consultation~~ options counseling for assisted living and the need to receive and verify the ~~consultation~~ counseling prior to signing a ~~lease or~~ contract. Long-term care ~~consultation for registered housing with services~~ options counseling for assisted living is provided as determined by the commissioner of human services. The service is delivered under a partnership between lead agencies as defined in subdivision ~~1a~~ 10, paragraph ~~(d)~~ (g), and the Area Agencies on Aging, and is a point of entry to a combination of telephone-based long-term care options counseling provided by Senior LinkAge Line and in-person long-term care consultation provided by lead agencies. The point of entry service must be provided within five working days of the request of the prospective resident as follows:

(1) the ~~consultation~~ counseling shall be conducted with the prospective resident, or in the alternative, the resident's designated or legal representative, if:

(i) the resident verbally requests; or

(ii) the ~~registered housing with services provider~~ assisted living facility has documentation of the designated or legal representative's authority to enter into a lease or contract on behalf of the prospective resident and accepts the documentation in good faith;

(2) the ~~consultation~~ counseling shall be performed in a manner that provides objective and complete information;

(3) the ~~consultation~~ counseling must include a review of the prospective resident's reasons for considering ~~housing with services~~ assisted living services, the prospective resident's personal goals, a discussion of the prospective resident's immediate and projected long-term care needs, and alternative community services or ~~housing with services~~ settings that may meet the prospective resident's needs;

(4) the prospective resident ~~shall~~ must be informed of the availability of ~~a face-to-face~~ an in-person visit from a long-term care consultation team member at no charge to the prospective resident to assist the prospective resident in assessment and planning to meet the prospective resident's long-term care needs; and

(5) verification of counseling shall be generated and provided to the prospective resident by Senior LinkAge Line upon completion of the telephone-based counseling.

(c) ~~Housing with services establishments registered under chapter 144D~~ An assisted living facility licensed under chapter 144G shall:

(1) inform each prospective resident or the prospective resident's designated or legal representative of the availability of and contact information for ~~consultation~~ options counseling services under this subdivision;

(2) receive a copy of the verification of counseling prior to executing a ~~lease or service~~ contract with the prospective resident~~, and prior to executing a service contract with individuals who have previously entered into lease-only arrangements~~; and

(3) retain a copy of the verification of counseling as part of the resident's file.

(d) Emergency admissions to ~~registered housing with services establishments~~ licensed assisted living facilities prior to consultation under paragraph (b) are permitted according to policies established by the commissioner.

Sec. 3. Minnesota Statutes 2020, section 256B.0911, subdivision 3d, is amended to read:

Subd. 3d. **Exemptions from long-term care options counseling for assisted living.** Individuals shall be exempt from the requirements outlined in subdivision ~~3e~~ 7e in the following circumstances:

(1) the individual is seeking a lease-only arrangement in a subsidized housing setting;

(2) the individual has previously received a long-term care consultation assessment under ~~this~~ section 256B.0911. In this instance, the assessor who completes the long-term care consultation assessment will issue a verification code and provide it to the individual;

(3) the individual is receiving or is being evaluated for hospice services from a hospice provider licensed under sections 144A.75 to 144A.755; or

(4) the individual has used financial planning services and created a long-term care plan as defined by the commissioner in the 12 months prior to signing a lease or contract with a ~~registered housing with services establishment~~ licensed assisted living facility.

Sec. 4. Minnesota Statutes 2020, section 256B.0911, subdivision 3e, is amended to read:

Subd. 3e. ~~**Consultation**~~ **Long-term care options counseling at hospital discharge.** (a) Hospitals shall refer all individuals described in paragraph (b) prior to discharge from an inpatient hospital stay to the Senior LinkAge Line for long-term care options counseling. Hospitals shall make these referrals using referral protocols and processes developed under ~~section 256.975,~~ subdivision 7. The purpose of the counseling is to support persons with current or anticipated long-term care needs in making informed choices among options that include the most cost-effective and least restrictive setting.

(b) The individuals who shall be referred under paragraph (a) include older adults who are at risk of nursing home placement. Protocols for identifying at-risk individuals shall be developed under ~~section 256.975,~~ subdivision 7, paragraph (b), clause (12).

(c) Counseling provided under this subdivision shall meet the requirements for the consultation required under subdivision ~~3e~~ 7e.

Sec. 5. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 10. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Available service and setting options" or "available options," with respect to the home and community-based waivers under chapter 256S and sections 256B.092 and 256B.49, means all services and settings defined under the waiver plan for which a waiver applicant or waiver participant is eligible.

(c) "Competitive employment" means work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting, and for which an

individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(d) "Cost-effective" means community services and living arrangements that cost the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under chapter 256S or section 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program.

(e) "Independent living" means living in a setting that is not controlled by a provider.

(f) "Informed choice" has the meaning given in section 256B.4905, subdivision 1a.

(g) "Lead agency" means a county administering or a Tribe or health plan under contract with the commissioner to administer long-term care consultation services.

(h) "Long-term care consultation services" means the activities described in subdivision 11.

(i) "Long-term care options counseling" means the services provided by sections 256.01, subdivision 24, and 256.975, subdivision 7, and also includes telephone assistance and follow-up after a long-term care consultation assessment has been completed.

(j) "Long-term care options counseling for assisted living" means the services provided under section 256.975, subdivisions 7e to 7g.

(k) "Minnesota health care programs" means the medical assistance program under this chapter and the alternative care program under section 256B.0913.

(l) "Person-centered planning" is a process that includes the active participation of a person in the planning of the person's services, including in making meaningful and informed choices about the person's own goals, talents, and objectives, as well as making meaningful and informed choices about the services the person receives, the settings in which the person receives the services, and the setting in which the person lives.

(m) "Preadmission screening" means the services provided under section 256.975, subdivisions 7a to 7c.

Sec. 6. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 11. **Long-term care consultation services.** The following activities are included in long-term care consultation services:

(1) intake for and access to assistance in identifying services needed to maintain an individual in the most inclusive environment;

(2) transfer or referral to long-term care options counseling services for telephone assistance and follow-up after a person requests assistance in identifying community supports without participating in a complete long-term care consultation assessment;

(3) long-term care consultation assessments conducted according to subdivisions 17 to 21, 23, or 24, which may be completed in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DDs), regional treatment center, or the person's current or planned residence;

(4) providing recommendations for and referrals to cost-effective community services that are available to the individual;

(5) providing recommendations for institutional placement when there are no cost-effective community services available;

(6) providing information regarding eligibility for Minnesota health care programs;

(7) determining service eligibility for the following state plan services:

(i) personal care assistance services under section 256B.0625, subdivisions 19a and 19c;

(ii) consumer support grants under section 256.476; or

(iii) community first services and supports under section 256B.85;

(8) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024, gaining access to the following services, including obtaining necessary diagnostic information to determine eligibility:

(i) relocation targeted case management services available under section 256B.0621, subdivision 2, clause (4);

(ii) case management services targeted to vulnerable adults or people with developmental disabilities under section 256B.0924; and

(iii) case management services targeted to people with developmental disabilities under Minnesota Rules, part 9525.0016;

(9) determining eligibility for semi-independent living services under section 252.275, including obtaining necessary diagnostic information;

(10) determining home and community-based waiver and other service eligibility as required under chapter 256S and sections 256B.0913, 256B.092, and 256B.49, including:

(i) level of care determination for individuals who need an institutional level of care as determined under subdivision 26;

(ii) appropriate referrals to obtain necessary diagnostic information; and

(iii) an eligibility determination for consumer-directed community supports;

(11) providing information about competitive employment, with or without supports, for school-age youth and working-age adults and referrals to the Disability Hub and Disability Benefits 101 to ensure that an informed choice about competitive employment can be made;

(12) providing information about independent living to ensure that an informed choice about independent living can be made;

(13) providing information about self-directed services and supports, including self-directed funding options, to ensure that an informed choice about self-directed options can be made;

(14) developing an individual's person-centered assessment summary; and

(15) providing access to assistance to transition people back to community settings after institutional admission.

Sec. 7. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 12. **Exception to use of MnCHOICES assessment; contracted assessors.** (a) A lead agency that has not implemented MnCHOICES assessments and uses contracted assessors as of January 1, 2022, is not subject to the requirements of subdivisions 11, clauses (7) to (9); 13; 14, paragraphs (a) to (c); 16 to 21; 23; 24; and 29 to 31.

(b) This subdivision expires upon statewide implementation of MnCHOICES assessments. The commissioner shall notify the revisor of statutes when statewide implementation has occurred.

Sec. 8. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 13. **MnCHOICES assessor qualifications, training, and certification.** (a) The commissioner shall develop and implement a curriculum and an assessor certification process.

(b) MnCHOICES certified assessors must:

(1) either have a bachelor's degree in social work, nursing with a public health nursing certificate, or other closely related field with at least one year of home and community-based experience or be a registered nurse with at least two years of home and community-based experience; and

(2) have received training and certification specific to assessment and consultation for long-term care services in the state.

(c) Certified assessors shall demonstrate best practices in assessment and support planning, including person-centered planning principles, and have a common set of skills that ensures consistency and equitable access to services statewide.

(d) Certified assessors must be recertified every three years.

Sec. 9. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 14. **Use of MnCHOICES certified assessors required.** (a) Each lead agency shall use MnCHOICES certified assessors who have completed MnCHOICES training and the certification process determined by the commissioner in subdivision 13.

(b) Each lead agency must ensure that the lead agency has sufficient numbers of certified assessors to provide long-term consultation assessment and support planning within the timelines and parameters of the service.

(c) A lead agency may choose, according to departmental policies, to contract with a qualified, certified assessor to conduct assessments and reassessments on behalf of the lead agency.

(d) Tribes and health plans under contract with the commissioner must provide long-term care consultation services as specified in the contract.

(e) A lead agency must provide the commissioner with an administrative contact for communication purposes.

Sec. 10. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 15. **Long-term care consultation team.** (a) Each county board of commissioners shall establish a long-term care consultation team. Two or more counties may collaborate to establish a joint local long-term care consultation team or teams.

(b) Each lead agency shall establish and maintain a team of certified assessors qualified under subdivision 13. Each team member is responsible for providing consultation with other team members upon request. The team is responsible for providing long-term care consultation services to all persons located in the county who request the services, regardless of eligibility for Minnesota health care programs. The team of certified assessors must include, at a minimum:

(1) a social worker; and

(2) a public health nurse or registered nurse.

(c) The commissioner shall allow arrangements and make recommendations that encourage counties and Tribes to collaborate to establish joint local long-term care consultation teams to ensure that long-term care consultations are done within the timelines and parameters of the service. This includes integrated service models as required in subdivision 1, paragraph (c).

Sec. 11. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 16. **MnCHOICES certified assessors; responsibilities.** (a) Certified assessors must use person-centered planning principles to conduct an interview that identifies what is important to the person; the person's needs for supports and health and safety concerns; and the person's abilities, interests, and goals.

(b) Certified assessors are responsible for:

(1) ensuring persons are offered objective, unbiased access to resources;

(2) ensuring persons have the needed information to support informed choice, including where and how they choose to live and the opportunity to pursue desired employment;

(3) determining level of care and eligibility for long-term services and supports;

(4) using the information gathered from the interview to develop a person-centered assessment summary that reflects identified needs and support options within the context of values, interests, and goals important to the person; and

(5) providing the person with an assessment summary of findings, support options, and agreed-upon next steps.

Sec. 12. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 17. **MnCHOICES assessments.** (a) A person requesting long-term care consultation services must be visited by a long-term care consultation team within 20 calendar days after the date on which an assessment was requested or recommended. Assessments must be conducted according to this subdivision and subdivisions 19 to 21, 23, 24, and 29 to 31.

(b) Lead agencies shall use certified assessors to conduct the assessment.

(c) For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

(d) The lead agency must use the MnCHOICES assessment provided by the commissioner to complete a comprehensive, conversation-based, person-centered assessment. The assessment must include the health, psychological, functional, environmental, and social needs of the individual necessary to develop a person-centered assessment summary that meets the individual's needs and preferences.

(e) Except as provided in subdivision 24, an assessment must be conducted by a certified assessor in an in-person conversational interview with the person being assessed.

Sec. 13. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 18. **Exception to use of MnCHOICES assessments; long-term care consultation team visit; notice.** (a) Until statewide implementation of MnCHOICES assessments, the requirement under subdivision 16, paragraph (a), does not apply to an assessment of a person requesting personal care assistance services. The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of statewide implementation.

(b) This subdivision expires upon statewide implementation of MnCHOICES assessments. The commissioner shall notify the revisor of statutes when statewide implementation has occurred.

Sec. 14. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 19. **MnCHOICES assessments; third-party participation.** (a) The person's legal representative must provide input during the assessment process and may do so remotely if requested.

(b) At the request of the person, other individuals may participate in the assessment to provide information on the needs, strengths, and preferences of the person necessary to complete the assessment and assessment summary. Except for legal representatives or family members invited by the person, a person participating in the assessment may not be a provider of service or have any financial interest in the provision of services.

(c) For a person assessed for elderly waiver customized living or adult day services under chapter 256S, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment must notify the provider of the date by which to submit this information. This information must be provided to the person conducting the assessment prior to the assessment.

(d) For a person assessed for waiver services under section 256B.092 or 256B.49, with the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs that the person completed in consultation with someone who is known to the person and who has interaction with the person on a regular basis. The provider must submit the report at least 60 days before the end of the person's current service agreement. The certified assessor must consider the content of the submitted report prior to finalizing the person's assessment or reassessment.

Sec. 15. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 20. **MnCHOICES assessments; duration of validity.** (a) An assessment that is completed as part of an eligibility determination for multiple programs for the alternative care, elderly waiver, developmental disabilities, community access for disability inclusion, community alternative care, and brain injury waiver programs under chapter 256S and sections 256B.0913, 256B.092, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of the assessment.

(b) The effective eligibility start date for programs in paragraph (a) can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated and documented in the department's Medicaid Management Information System (MMIS). Notwithstanding retroactive medical assistance coverage of

state plan services, the effective date of eligibility for programs included in paragraph (a) cannot be prior to the completion date of the most recent updated assessment.

(c) If an eligibility update is completed within 90 days of the previous assessment and documented in the department's Medicaid Management Information System (MMIS), the effective date of eligibility for programs included in paragraph (a) is the date of the previous in-person assessment when all other eligibility requirements are met.

Sec. 16. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 21. **MnCHOICES assessments; exceptions following institutional stay.** (a) A person receiving home and community-based waiver services under section 256B.0913, 256B.092, or 256B.49 or chapter 256S may return to a community with home and community-based waiver services under the same waiver without being assessed or reassessed under this section if the person temporarily entered one of the following for 121 or fewer days:

(1) a hospital;

(2) an institution of mental disease;

(3) a nursing facility;

(4) an intensive residential treatment services program;

(5) a transitional care unit; or

(6) an inpatient substance use disorder treatment setting.

(b) Nothing in paragraph (a) changes annual long-term care consultation reassessment requirements, payment for institutional or treatment services, medical assistance financial eligibility, or any other law.

Sec. 17. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 22. **MnCHOICES reassessments.** (a) Prior to a reassessment, the certified assessor must review the person's most recent assessment.

(b) Reassessments must:

(1) be tailored using the professional judgment of the assessor to the person's known needs, strengths, preferences, and circumstances;

(2) provide information to support the person's informed choice and opportunities to express choice regarding activities that contribute to quality of life, as well as information and opportunity to identify goals related to desired employment, community activities, and preferred living environment;

(3) provide a review of the most recent assessment, the current support plan's effectiveness and monitoring of services, and the development of an updated person-centered assessment summary;

(4) verify continued eligibility, offer alternatives as warranted, and provide an opportunity for quality assurance of service delivery; and

(5) be conducted annually or as required by federal and state laws.

(c) The certified assessor and the individual responsible for developing the support plan must ensure the continuity of care for the person receiving services and complete the updated assessment summary and the updated support plan no more than 60 days after the reassessment visit.

(d) The commissioner shall develop mechanisms for providers and case managers to share information with the assessor to facilitate a reassessment and support planning process tailored to the person's current needs and preferences.

Sec. 18. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 23. **MnCHOICES reassessments; option for alternative and self-directed waiver services.** (a) At the time of reassessment, the certified assessor shall assess a person receiving waiver residential supports and services and currently residing in a setting listed in clauses (1) to (5) to determine if the person would prefer to be served in a community-living setting as defined in section 256B.49, subdivision 23, or in a setting not controlled by a provider, or to receive integrated community supports as described in section 245D.03, subdivision 1, paragraph (c), clause (8). The certified assessor shall offer the person through a person-centered planning process the option to receive alternative housing and service options. This paragraph applies to those currently residing in a:

(1) community residential setting;

(2) licensed adult foster care home that is either not the primary residence of the license holder or in which the license holder is not the primary caregiver;

(3) family adult foster care residence;

(4) customized living setting; or

(5) supervised living facility.

(b) At the time of reassessment, the certified assessor shall assess each person receiving waiver day services to determine if that person would prefer to receive employment services as described in section 245D.03, subdivision 1, paragraph (c), clauses (5) to (7). The certified assessor shall describe to the person through a person-centered planning process the option to receive employment services.

(c) At the time of reassessment, the certified assessor shall assess each person receiving non-self-directed waiver services to determine if that person would prefer an available service and setting option that would permit self-directed services and supports. The certified assessor shall describe to the person through a person-centered planning process the option to receive self-directed services and supports.

Sec. 19. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 24. **Remote reassessments.** (a) Assessments performed according to subdivisions 17 to 21 and 23 must be in person unless the assessment is a reassessment meeting the requirements of this subdivision. Remote reassessments conducted by interactive video or telephone may substitute for in-person reassessments.

(b) For services provided by the developmental disabilities waiver under section 256B.092, and the community access for disability inclusion, community alternative care, and brain injury waiver programs under section 256B.49, remote reassessments may be substituted for two consecutive reassessments if followed by an in-person reassessment.

(c) For services provided by alternative care under section 256B.0913, essential community supports under section 256B.0922, and the elderly waiver under chapter 256S, remote reassessments may be substituted for one reassessment if followed by an in-person reassessment.

(d) A remote reassessment is permitted only if the person being reassessed, or the person's legal representative, and the lead agency case manager both agree that there is no change in the person's condition, there is no need for a change in service, and that a remote reassessment is appropriate.

(e) The person being reassessed, or the person's legal representative, may refuse a remote reassessment at any time.

(f) During a remote reassessment, if the certified assessor determines an in-person reassessment is necessary in order to complete the assessment, the lead agency shall schedule an in-person reassessment.

(g) All other requirements of an in-person reassessment apply to a remote reassessment, including updates to a person's support plan.

Sec. 20. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 25. **Reassessments for Rule 185 case management.** Unless otherwise required by federal law, the county agency is not required to conduct or arrange for an annual needs reassessment by a certified assessor for people receiving Rule 185 case management under Minnesota Rules, part 9525.0016. The case manager who works on behalf of the person to identify the person's needs and to minimize the impact of the disability on the person's life must instead develop a person-centered service plan based on the person's assessed needs and preferences. The person-centered service plan must be reviewed annually for persons with developmental disabilities who are receiving only case management services under Minnesota Rules, part 9525.0016, and who make an informed choice to decline an assessment under this section.

Sec. 21. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 26. **Determination of institutional level of care.** (a) The determination of need for hospital and intermediate care facility levels of care must be made according to criteria developed by the commissioner, and in section 256B.092, using forms developed by the commissioner.

(b) The determination of need for nursing facility level of care must be made based on criteria in section 144.0724, subdivision 11.

Sec. 22. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 27. **Transition assistance.** (a) Lead agency certified assessors shall provide transition assistance to persons residing in a nursing facility, hospital, regional treatment center, or intermediate care facility for persons with developmental disabilities who request or are referred for assistance.

(b) Transition assistance must include:

(1) assessment;

(2) referrals to long-term care options counseling under section 256.975, subdivision 7, for support plan implementation and to Minnesota health care programs, including home and community-based waiver services and consumer-directed options through the waivers; and

(3) referrals to programs that provide assistance with housing.

(c) Transition assistance must also include information about the Centers for Independent Living, Disability Hub, and other organizations that can provide assistance with relocation efforts and information about contacting these organizations to obtain their assistance and support.

(d) The lead agency shall ensure that:

(1) referrals for in-person assessments are taken from long-term care options counselors as provided for in section 256.975, subdivision 7, paragraph (b), clause (11);

(2) persons assessed in institutions receive information about available transition assistance;

(3) the assessment is completed for persons within 20 calendar days of the date of request or recommendation for assessment;

(4) there is a plan for transition and follow-up for the individual's return to the community, including notification of other local agencies when a person may require assistance from agencies located in another county; and

(5) relocation targeted case management as defined in section 256B.0621, subdivision 2, clause (4), is authorized for an eligible medical assistance recipient.

Sec. 23. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 28. **Transition assistance; nursing home residents under 65 years of age.** (a) Upon referral from the Senior LinkAge Line, individuals under 65 years of age who are admitted to nursing facilities on an emergency basis with only a telephone screening must receive an in-person assessment based on review of data from the long-term care consultation team member of the county in which the facility is located or from the recipient's county case manager within the timeline established by the commissioner.

(b) At the in-person assessment, the long-term care consultation team member or county case manager must:

(1) perform the activities required under subdivision 27; and

(2) present information about home and community-based options, including consumer-directed options, so the individual can make informed choices.

(c) If the individual chooses home and community-based services, the long-term care consultation team member or case manager must complete a written relocation plan within 20 working days of the visit. The plan must describe the services needed to move the individual out of the facility and a timeline for the move that is designed to ensure a smooth transition to the individual's home and community.

(d) For individuals under 21 years of age, a screening interview that recommends nursing facility admission must be in person and approved by the commissioner before the individual is admitted to the nursing facility.

(e) An individual under 65 years of age residing in a nursing facility must receive an in-person assessment at least every 12 months to review the person's service choices and available alternatives unless the individual indicates in writing that annual visits are not desired. In this case, the individual must receive an in-person assessment at least once every 36 months for the same purposes.

(f) Notwithstanding subdivision 33, the commissioner may pay county agencies directly for in-person assessments for individuals under 65 years of age who are being considered for placement or residing in a nursing facility.

Sec. 24. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 29. **Support planning.** (a) The certified assessor and the individual responsible for developing the support plan must complete the assessment summary and the support plan no more than 60 calendar days after the assessment visit.

(b) The person or the person's legal representative must be provided with a written assessment summary within the timelines established by the commissioner, regardless of whether the person is eligible for Minnesota health care programs.

(c) For a person being assessed for elderly waiver services under chapter 256S, a provider who submitted information under subdivision 19, paragraph (c), must receive the final written support plan when available and the Residential Services Workbook.

(d) The written support plan must include:

(1) a summary of assessed needs as defined in subdivision 17, paragraphs (d) and (e);

(2) the individual's options and choices to meet identified needs, including all available options for:

(i) case management services and providers;

(ii) employment services, settings, and providers;

(iii) living arrangements;

(iv) self-directed services and supports, including self-directed budget options; and

(v) service provided in a non-disability-specific setting;

(3) identification of health and safety risks and how those risks will be addressed, including personal risk management strategies;

(4) referral information; and

(5) informal caregiver supports, if applicable.

(e) For a person determined eligible for state plan home care under subdivision 11, clause (7), the person or person's legal representative must also receive a copy of the home care service plan developed by the certified assessor.

Sec. 25. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 30. **Assessment and support planning; supplemental information.** The lead agency must give the person receiving long-term care consultation services or the person's legal representative materials and forms supplied by the commissioner containing the following information:

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available were offered to the person;

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects nursing facility placement. If the person selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and screening for developmental disability and mental illness collected during the assessment to the long-term care options counselor using forms provided by the commissioner;

(4) the role of long-term care consultation assessment and support planning in eligibility determination for waiver and alternative care programs and state plan home care, case management, and other services as defined in subdivision 11, clauses (7) to (10);

(5) information about Minnesota health care programs;

(6) the person's freedom to accept or reject the recommendations of the team;

(7) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;

(8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in subdivision 26 and regarding eligibility for all services and programs as defined in subdivision 11, clauses (7) to (10);

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 11, clauses (5), (7) to (10), and (15), and the decision regarding the need for institutional level of care or the lead agency's final decisions regarding public programs eligibility according to section 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right to the person and must visually point out where in the document the right to appeal is stated; and

(10) documentation that available options for employment services, independent living, and self-directed services and supports were described to the person.

Sec. 26. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 31. **Assessment and support planning; right to final decision.** The person has the right to make the final decision:

(1) between institutional placement and community placement after the recommendations have been provided under subdivision 30, clause (1), except as provided in section 256.975, subdivision 7a, paragraph (d);

(2) between community placement in a setting controlled by a provider and living independently in a setting not controlled by a provider;

(3) between day services and employment services; and

(4) regarding available options for self-directed services and supports, including self-directed funding options.

Sec. 27. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 32. **Administrative activity.** (a) The commissioner shall:

(1) streamline the processes, including timelines for when assessments need to be completed;

(2) provide the services in this section; and

(3) implement integrated solutions to automate the business processes to the extent necessary for support plan approval, reimbursement, program planning, evaluation, and policy development.

(b) The commissioner shall work with lead agencies responsible for conducting long-term care consultation services to:

(1) modify the MnCHOICES application and assessment policies to create efficiencies while ensuring federal compliance with medical assistance and long-term services and supports eligibility criteria; and

(2) develop a set of measurable benchmarks sufficient to demonstrate quarterly improvement in the average time per assessment and other mutually agreed upon measures of increasing efficiency.

(c) The commissioner shall collect data on the benchmarks developed under paragraph (b) and provide to the lead agencies and the chairs and ranking minority members of the legislative committees with jurisdiction over human services an annual trend analysis of the data in order to demonstrate the commissioner's compliance with the requirements of this subdivision.

Sec. 28. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 33. **Payment for long-term care consultation services.** (a) Payments for long-term care consultation services are available to the county or counties to cover staff salaries and expenses to provide the services described in subdivision 11. The county shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide long-term care consultation services while meeting the state's long-term care outcomes and objectives as defined in subdivision 1.

(b) The county is accountable for meeting local objectives as approved by the commissioner in the biennial home and community-based services quality assurance plan on a form provided by the commissioner.

(c) The state shall pay 81.9 percent of the nonfederal share as reimbursement to the counties.

Sec. 29. **DIRECTION TO COMMISSIONER; TRANSITION PROCESS.**

(a) The commissioner of human services shall update references to statutes recodified in this act when printed material is replaced and new printed material is obtained in the normal course of business. The commissioner is not required to replace existing printed material to comply with this act.

(b) The commissioner of human services shall update references to statutes recodified in this act when online documents and websites are edited in the normal course of business. The commissioner is not required to edit online documents and websites merely to comply with this act.

(c) The commissioner of human services shall update references to statutes recodified in this act when the home and community-based service waiver plans are updated in the normal course of business. The commissioner is not required to update the home and community-based service waiver plans merely to comply with this act.

Sec. 30. **REVISOR INSTRUCTION.**

(a) The revisor of statutes shall renumber each section of Minnesota Statutes listed in column A with the number listed in column B. The revisor shall also make necessary cross-reference changes consistent with the renumbering.

| Column A | Column B |
|---|---|
| 256B.0911, subdivision 3c | 256.975, subdivision 7e |
| 256B.0911, subdivision 3d | 256.975, subdivision 7f |
| 256B.0911, subdivision 3e | 256.975, subdivision 7g |

(b) The revisor of statutes, in consultation with the House of Representatives Research Department; the Office of Senate Counsel, Research and Fiscal Analysis; and the Department of Human Services, shall make necessary cross-reference changes and remove statutory cross-references in Minnesota Statutes to conform with the recodification in this act. The revisor may make technical and other necessary changes to sentence structure to preserve the meaning of the text. The revisor may alter the coding in this act to incorporate statutory

changes made by other law in the 2022 regular legislative session. If a provision stricken in this act is also amended in the 2022 regular legislative session by other law, the revisor shall restore the stricken language and give effect to the amendment, notwithstanding Minnesota Statutes, section 645.30.

Sec. 31. **REPEALER.**

Minnesota Statutes 2020, section 256B.0911, subdivisions 2b, 2c, 3, 3b, 3g, 4d, 4e, 5, and 6, are repealed.

Minnesota Statutes 2021 Supplement, section 256B.0911, subdivisions 1a, 3a, and 3f, are repealed.

Sec. 32. **EFFECTIVE DATE.**

Sections 1 to 31 are effective July 1, 2022.

## ARTICLE 2
## CONFORMING CHANGES

Section 1. Minnesota Statutes 2021 Supplement, section 144.0724, subdivision 4, is amended to read:

Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit to the federal database MDS assessments that conform with the assessment schedule defined by the Long Term Care Facility Resident Assessment Instrument User's Manual, version 3.0, or its successor issued by the Centers for Medicare and Medicaid Services. The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, to replace or supplement the current version of the manual or document.

(b) The assessments required under the Omnibus Budget Reconciliation Act of 1987 (OBRA) used to determine a case mix classification for reimbursement include the following:

(1) a new admission comprehensive assessment, which must have an assessment reference date (ARD) within 14 calendar days after admission, excluding readmissions;

(2) an annual comprehensive assessment, which must have an ARD within 92 days of a previous quarterly review assessment or a previous comprehensive assessment, which must occur at least once every 366 days;

(3) a significant change in status comprehensive assessment, which must have an ARD within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition, whether an improvement or a decline, and regardless of the amount of time since the last comprehensive assessment or quarterly review assessment;

(4) a quarterly review assessment must have an ARD within 92 days of the ARD of the previous quarterly review assessment or a previous comprehensive assessment;

(5) any significant correction to a prior comprehensive assessment, if the assessment being corrected is the current one being used for RUG classification;

(6) any significant correction to a prior quarterly review assessment, if the assessment being corrected is the current one being used for RUG classification;

(7) a required significant change in status assessment when:

(i) all speech, occupational, and physical therapies have ended. The ARD of this assessment must be set on day eight after all therapy services have ended; and

(ii) isolation for an infectious disease has ended. The ARD of this assessment must be set on day 15 after isolation has ended; and

(8) any modifications to the most recent assessments under clauses (1) to (7).

(c) In addition to the assessments listed in paragraph (b), the assessments used to determine nursing facility level of care include the following:

(1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by the Senior LinkAge Line or other organization under contract with the Minnesota Board on Aging; and

(2) a nursing facility level of care determination as provided for under section 256B.0911, subdivision ~~4e~~ 26, as part of a face-to-face long-term care consultation assessment completed under section 256B.0911, by a county, tribe, or managed care organization under contract with the Department of Human Services.

Sec. 2. Minnesota Statutes 2020, section 144.0724, subdivision 11, is amended to read:

Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance payment of long-term care services, a recipient must be determined, using assessments defined in subdivision 4, to meet one of the following nursing facility level of care criteria:

(1) the person requires formal clinical monitoring at least once per day;

(2) the person needs the assistance of another person or constant supervision to begin and complete at least four of the following activities of living: bathing, bed mobility, dressing, eating, grooming, toileting, transferring, and walking;

(3) the person needs the assistance of another person or constant supervision to begin and complete toileting, transferring, or positioning and the assistance cannot be scheduled;

(4) the person has significant difficulty with memory, using information, daily decision making, or behavioral needs that require intervention;

(5) the person has had a qualifying nursing facility stay of at least 90 days;

(6) the person meets the nursing facility level of care criteria determined 90 days after admission or on the first quarterly assessment after admission, whichever is later; or

(7) the person is determined to be at risk for nursing facility admission or readmission through a face-to-face long-term care consultation assessment as specified in section 256B.0911, ~~subdivision 3a, 3b, or 4d~~ subdivisions 17 to 21, 23, 24, 27, or 28, by a county, tribe, or managed care organization under contract with the Department of Human Services. The person is considered at risk under this clause if the person currently lives alone or will live alone or be homeless without the person's current housing and also meets one of the following criteria:

(i) the person has experienced a fall resulting in a fracture;

(ii) the person has been determined to be at risk of maltreatment or neglect, including self-neglect; or

(iii) the person has a sensory impairment that substantially impacts functional ability and maintenance of a community residence.

(b) The assessment used to establish medical assistance payment for nursing facility services must be the most recent assessment performed under subdivision 4, paragraph (b), that occurred no more than 90 calendar days before the effective date of medical assistance eligibility for payment of long-term care services. In no case shall medical assistance payment for long-term care services occur prior to the date of the determination of nursing facility level of care.

(c) The assessment used to establish medical assistance payment for long-term care services provided under chapter 256S and section 256B.49 and alternative care payment for services provided under section 256B.0913 must be the most recent face-to-face assessment performed under section 256B.0911, ~~subdivision 3a, 3b, or 4d~~ subdivisions 17

to 21, 23, 24, 27, or 28, that occurred no more than 60 calendar days before the effective date of medical assistance eligibility for payment of long-term care services.

Sec. 3. Minnesota Statutes 2021 Supplement, section 144.0724, subdivision 12, is amended to read:

Subd. 12. **Appeal of nursing facility level of care determination.** (a) A resident or prospective resident whose level of care determination results in a denial of long-term care services can appeal the determination as outlined in section 256B.0911, subdivision ~~3a, paragraph (h)~~ 30, clause (9).

(b) The commissioner of human services shall ensure that notice of changes in eligibility due to a nursing facility level of care determination is provided to each affected recipient or the recipient's guardian at least 30 days before the effective date of the change. The notice shall include the following information:

(1) how to obtain further information on the changes;

(2) how to receive assistance in obtaining other services;

(3) a list of community resources; and

(4) appeal rights.

Sec. 4. Minnesota Statutes 2020, section 256.975, subdivision 7a, is amended to read:

Subd. 7a. **Preadmission screening activities related to nursing facility admissions.** (a) All individuals seeking admission to Medicaid-certified nursing facilities, including certified boarding care facilities, must be screened prior to admission regardless of income, assets, or funding sources for nursing facility care, except as described in subdivision 7b, paragraphs (a) and (b). The purpose of the screening is to determine the need for nursing facility level of care as described in section 256B.0911, subdivision ~~4e~~ 26, and to complete activities required under federal law related to mental illness and developmental disability as outlined in paragraph (b).

(b) A person who has a diagnosis or possible diagnosis of mental illness or developmental disability must receive a preadmission screening before admission regardless of the exemptions outlined in subdivision 7b, paragraphs (a) and (b), to identify the need for further evaluation and specialized services, unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law 101-508.

(c) The following criteria apply to the preadmission screening:

(1) requests for preadmission screenings must be submitted via an online form developed by the commissioner;

(2) the Senior LinkAge Line must use forms and criteria developed by the commissioner to identify persons who require referral for further evaluation and determination of the need for specialized services; and

(3) the evaluation and determination of the need for specialized services must be done by:

(i) a qualified independent mental health professional, for persons with a primary or secondary diagnosis of a serious mental illness; or

(ii) a qualified developmental disability professional, for persons with a primary or secondary diagnosis of developmental disability. For purposes of this requirement, a qualified developmental disability professional must meet the standards for a qualified developmental disability professional under Code of Federal Regulations, title 42, section 483.430.

(d) The local county mental health authority or the state developmental disability authority under Public Laws 100-203 and 101-508 may prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Laws 100-203 and 101-508. For purposes of this section, "specialized services" for a person with developmental disability means active treatment as that term is defined under Code of Federal Regulations, title 42, section 483.440 (a)(1).

(e) In assessing a person's needs, the screener shall:

(1) use an automated system designated by the commissioner;

(2) consult with care transitions coordinators, physician, or advanced practice registered nurse; and

(3) consider the assessment of the individual's physician or advanced practice registered nurse.

(f) Other personnel may be included in the level of care determination as deemed necessary by the screener.

Sec. 5. Minnesota Statutes 2020, section 256.975, subdivision 7b, is amended to read:

Subd. 7b. **Exemptions and emergency admissions.** (a) Exemptions from the federal screening requirements outlined in subdivision 7a, paragraphs (b) and (c), are limited to:

(1) a person who, having entered an acute care facility from a certified nursing facility, is returning to a certified nursing facility; or

(2) a person transferring from one certified nursing facility in Minnesota to another certified nursing facility in Minnesota.

(b) Persons who are exempt from preadmission screening for purposes of level of care determination include:

(1) persons described in paragraph (a);

(2) an individual who has a contractual right to have nursing facility care paid for indefinitely by the Veterans Administration;

(3) an individual enrolled in a demonstration project under section 256B.69, subdivision 8, at the time of application to a nursing facility; and

(4) an individual currently being served under the alternative care program or under a home and community-based services waiver authorized under section 1915(c) of the federal Social Security Act.

(c) Persons admitted to a Medicaid-certified nursing facility from the community on an emergency basis as described in paragraph (d) or from an acute care facility on a nonworking day must be screened the first working day after admission.

(d) Emergency admission to a nursing facility prior to screening is permitted when all of the following conditions are met:

(1) a person is admitted from the community to a certified nursing or certified boarding care facility during Senior LinkAge Line nonworking hours;

(2) a physician or advanced practice registered nurse has determined that delaying admission until preadmission screening is completed would adversely affect the person's health and safety;

(3) there is a recent precipitating event that precludes the client from living safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's inability to continue to provide care;

(4) the attending physician or advanced practice registered nurse has authorized the emergency placement and has documented the reason that the emergency placement is recommended; and

(5) the Senior LinkAge Line is contacted on the first working day following the emergency admission.

(e) Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation, care in an emergency room without hospital admission, or following hospital 24-hour bed care and from whom admission is being sought on a nonworking day.

~~(e)~~ (f) A nursing facility must provide written information to all persons admitted regarding the person's right to request and receive long-term care consultation services as defined in section 256B.0911, subdivision ~~1a~~ 11. The information must be provided prior to the person's discharge from the facility and in a format specified by the commissioner.

Sec. 6. Minnesota Statutes 2020, section 256.975, subdivision 7c, is amended to read:

Subd. 7c. **Screening requirements.** (a) A person may be screened for nursing facility admission by telephone or in a face-to-face screening interview. The Senior LinkAge Line shall identify each individual's needs using the following categories:

(1) the person needs no face-to-face long-term care consultation assessment completed under section 256B.0911, ~~subdivision 3a, 3b, or 4d~~ subdivisions 17 to 21, 24, 27 or 28, by a county, tribe, or managed care organization under contract with the Department of Human Services to determine the need for nursing facility level of care based on information obtained from other health care professionals;

(2) the person needs an immediate face-to-face long-term care consultation assessment completed under section 256B.0911, ~~subdivision 3a, 3b, or 4d~~ subdivisions 17 to 21, 24, 27, or 28, by a county, tribe, or managed care organization under contract with the Department of Human Services to determine the need for nursing facility level of care and complete activities required under subdivision 7a; or

(3) the person may be exempt from screening requirements as outlined in subdivision 7b, but will need ~~transitional~~ transition assistance after admission or in-person follow-along after a return home.

(b) The Senior LinkAge Line shall refer individuals under 65 years of age who are admitted to nursing facilities with only a telephone screening ~~must receive a face-to-face~~ for an in-person assessment from the long-term care consultation team member of the county in which the facility is located or from the recipient's county case manager ~~within 40 calendar days of admission~~ as described in section 256B.0911, subdivision ~~4d~~ 28, paragraph ~~(c)~~ (a).

(c) Persons admitted on a nonemergency basis to a Medicaid-certified nursing facility must be screened prior to admission.

(d) Screenings provided by the Senior LinkAge Line must include processes to identify persons who may require transition assistance described in subdivision 7, paragraph (b), clause (12), and section 256B.0911, subdivision ~~3b~~ 27.

Sec. 7. Minnesota Statutes 2020, section 256.975, subdivision 7d, is amended to read:

Subd. 7d. **Payment for preadmission screening.** ~~Funding~~ (a) The Department of Human Services shall provide funding for preadmission screening ~~shall be provided~~ to the Minnesota Board on Aging ~~by the Department of Human Services~~ to cover screener salaries and expenses to provide the services described in subdivisions 7a to 7c. The Minnesota Board on Aging shall:

(1) employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide preadmission screening and level of care determination services; and ~~shall~~

(2) seek to maximize federal funding for the service as provided under section 256.01, subdivision 2, paragraph (aa).

(b) The Department of Human Services shall provide funding for preadmission screening follow-up to the Disability Hub for the under-60 population to cover options counseling salaries and expenses to provide the services described in subdivisions 7a to 7c. The Disability Hub shall:

(1) employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide preadmission screening follow-up services; and

(2) seek to maximize federal funding for the service as provided under section 256.01, subdivision 2, paragraph (aa).

Sec. 8. Minnesota Statutes 2020, section 256B.051, subdivision 4, is amended to read:

Subd. 4. **Assessment requirements.** (a) An individual's assessment of functional need must be conducted by one of the following methods:

(1) an assessor according to the criteria established in section 256B.0911, ~~subdivision 3a~~ subdivisions 17 to 21, 23, 24, and 29 to 31, using a format established by the commissioner;

(2) documented need for services as verified by a professional statement of need as defined in section 256I.03, subdivision 12; or

(3) according to the continuum of care coordinated assessment system established in Code of Federal Regulations, title 24, section 578.3, using a format established by the commissioner.

(b) An individual must be reassessed within one year of initial assessment, and annually thereafter.

Sec. 9. Minnesota Statutes 2020, section 256B.0646, is amended to read:

**256B.0646 MINNESOTA RESTRICTED RECIPIENT PROGRAM; PERSONAL CARE ASSISTANCE SERVICES.**

(a) When a recipient's use of personal care assistance services or community first services and supports under section 256B.85 results in abusive or fraudulent billing, the commissioner may place a recipient in the Minnesota restricted recipient program under Minnesota Rules, part 9505.2165. A recipient placed in the Minnesota restricted recipient program under this section must: (1) use a designated traditional personal care assistance provider agency; and (2) obtain a new assessment under section 256B.0911, including consultation with a registered or public health nurse on the long-term care consultation team pursuant to section 256B.0911, subdivision ~~3~~ 15, paragraph (b), clause (2).

(b) A recipient must comply with additional conditions for the use of personal care assistance services or community first services and supports if the commissioner determines it is necessary to prevent future misuse of personal care assistance services or abusive or fraudulent billing. Additional conditions may include but are not limited to restricting service authorizations for a duration of no more than one month and requiring a qualified professional to monitor and report services on a monthly basis.

(c) A recipient placed in the Minnesota restricted recipient program under this section may appeal the placement according to section 256.045.

Sec. 10. Minnesota Statutes 2020, section 256B.0659, subdivision 3a, is amended to read:

Subd. 3a. **Assessment; defined.** (a) "Assessment" means a review and evaluation of a recipient's need for personal care assistance services conducted in person. Assessments for personal care assistance services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county except when a long-term care consultation assessment is being conducted for the purposes of determining a person's eligibility for home and community-based waiver services including personal care assistance services according to section 256B.0911. During the transition to MnCHOICES, a certified

assessor may complete the assessment defined in this subdivision. An in-person assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistance services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. An in-person assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistance services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistance service. A service update may be completed by telephone, used when there is no need for an increase in personal care assistance services, and used for two consecutive assessments if followed by a face-to-face assessment. A service update must be completed on a form approved by the commissioner. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and ~~on going~~ ongoing consumer education. Assessments or reassessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.

(b) This subdivision expires when notification is given by the commissioner as described in section 256B.0911, subdivision ~~3a~~ 18.

Sec. 11. Minnesota Statutes 2020, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person is a citizen of the United States or a United States national;

(2) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, as determined under section 256B.0911, subdivision ~~4e~~ 26, but for the provision of services under the alternative care program;

(3) the person is age 65 or older;

(4) the person would be eligible for medical assistance within 135 days of admission to a nursing facility;

(5) the person is not ineligible for the payment of long-term care services by the medical assistance program due to an asset transfer penalty under section 256B.0595 or equity interest in the home exceeding $500,000 as stated in section 256B.056;

(6) the person needs long-term care services that are not funded through other state or federal funding, or other health insurance or other third-party insurance such as long-term care insurance;

(7) except for individuals described in clause (8), the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the monthly limit described under section 256S.18. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256S.04, and the alternative care program monthly service limit defined in this paragraph. If care-related supplies and equipment or environmental modifications and adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph;

(8) for individuals assigned a case mix classification A as described under section 256S.18, with (i) no dependencies in activities of daily living, or (ii) up to two dependencies in bathing, dressing, grooming, walking, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911, the monthly cost of alternative care services funded by the program cannot exceed $593 per month for all new participants enrolled in the program on or after July 1, 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in section 256S.18. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased exceed the difference between the client's monthly service limit defined in this clause and the limit described in clause (7) for case mix classification A; and

(9) the person is making timely payments of the assessed monthly fee. A person is ineligible if payment of the fee is over 60 days past due, unless the person agrees to:

(i) the appointment of a representative payee;

(ii) automatic payment from a financial account;

(iii) the establishment of greater family involvement in the financial management of payments; or

(iv) another method acceptable to the lead agency to ensure prompt fee payments.

(b) The lead agency may extend the client's eligibility as necessary while making arrangements to facilitate payment of past-due amounts and future premium payments. Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be reinstated for a period of 30 days.

~~(b)~~ (c) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown or waiver obligation. A person whose initial application for medical assistance and the elderly waiver program is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for the federally approved elderly waiver plan. Notwithstanding this provision, alternative care funds may not be used to pay for any service the cost of which: (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to pay a medical assistance income spenddown for a person who is eligible to participate in the federally approved elderly waiver program under the special income standard provision.

~~(c)~~ (d) Alternative care funding is not available for a person who resides in a licensed nursing home, certified boarding care home, hospital, or intermediate care facility, except for case management services which are provided in support of the discharge planning process for a nursing home resident or certified boarding care home resident to assist with a relocation process to a community-based setting.

~~(d)~~ (e) Alternative care funding is not available for a person whose income is greater than the maintenance needs allowance under section 256S.05, but equal to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal year for which alternative care eligibility is determined, who would be eligible for the elderly waiver with a waiver obligation.

Sec. 12. Minnesota Statutes 2020, section 256B.092, subdivision 1a, is amended to read:

Subd. 1a. **Case management services.** (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application.

(b) Case management service activities provided to or arranged for a person include:

(1) development of the person-centered coordinated service and support plan under subdivision 1b;

(2) informing the individual or the individual's legal guardian or conservator, or parent if the person is a minor, of service options, including all service options available under the waiver plan;

(3) consulting with relevant medical experts or service providers;

(4) assisting the person in the identification of potential providers of chosen services, including:

(i) providers of services provided in a non-disability-specific setting;

(ii) employment service providers;

(iii) providers of services provided in settings that are not controlled by a provider; and

(iv) providers of financial management services;

(5) assisting the person to access services and assisting in appeals under section 256.045;

(6) coordination of services, if coordination is not provided by another service provider;

(7) evaluation and monitoring of the services identified in the coordinated service and support plan, which must incorporate at least one annual face-to-face visit by the case manager with each person; and

(8) reviewing coordinated service and support plans and providing the lead agency with recommendations for service authorization based upon the individual's needs identified in the coordinated service and support plan.

(c) Case management service activities that are provided to the person with a developmental disability shall be provided directly by county agencies or under contract. Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has a financial interest in the provision of

any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision ~~1a, paragraph (e)~~ 10.

(d) Case managers are responsible for service provisions listed in paragraphs (a) and (b). Case managers shall collaborate with consumers, families, legal representatives, and relevant medical experts and service providers in the development and annual review of the person-centered coordinated service and support plan and habilitation plan.

(e) For persons who need a positive support transition plan as required in chapter 245D, the case manager shall participate in the development and ongoing evaluation of the plan with the expanded support team. At least quarterly, the case manager, in consultation with the expanded support team, shall evaluate the effectiveness of the plan based on progress evaluation data submitted by the licensed provider to the case manager. The evaluation must identify whether the plan has been developed and implemented in a manner to achieve the following within the required timelines:

(1) phasing out the use of prohibited procedures;

(2) acquisition of skills needed to eliminate the prohibited procedures within the plan's timeline; and

(3) accomplishment of identified outcomes.

If adequate progress is not being made, the case manager shall consult with the person's expanded support team to identify needed modifications and whether additional professional support is required to provide consultation.

(f) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ten hours of case management education and disability-related training each year. The education and training must include person-centered planning. For the purposes of this section, "person-centered planning" or "person-centered" has the meaning given in section 256B.0911, subdivision ~~1a, paragraph (f)~~ 10.

Sec. 13. Minnesota Statutes 2020, section 256B.092, subdivision 1b, is amended to read:

Subd. 1b. **Coordinated service and support plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written person-centered coordinated service and support plan that:

(1) is developed with and signed by the recipient within the timelines established by the commissioner and section 256B.0911, subdivision ~~3a, paragraph (e)~~ 29;

(2) includes the person's need for service, including identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

(3) reasonably ensures the health and welfare of the recipient;

(4) identifies the person's preferences for services as stated by the person, the person's legal guardian or conservator, or the parent if the person is a minor, including the person's choices made on self-directed options, services and supports to achieve employment goals, and living arrangements;

(5) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (o), of service and support providers, and identifies all available options for case management services and providers;

(6) identifies long-range and short-range goals for the person;

(7) identifies specific services and the amount and frequency of the services to be provided to the person based on assessed needs, preferences, and available resources. The person-centered coordinated service and support plan shall also specify other services the person needs that are not available;

(8) identifies the need for an individual program plan to be developed by the provider according to the respective state and federal licensing and certification standards, and additional assessments to be completed or arranged by the provider after service initiation;

(9) identifies provider responsibilities to implement and make recommendations for modification to the coordinated service and support plan;

(10) includes notice of the right to request a conciliation conference or a hearing under section 256.045;

(11) is agreed upon and signed by the person, the person's legal guardian or conservator, or the parent if the person is a minor, and the authorized county representative;

(12) is reviewed by a health professional if the person has overriding medical needs that impact the delivery of services; and

(13) includes the authorized annual and monthly amounts for the services.

(b) In developing the person-centered coordinated service and support plan, the case manager is encouraged to include the use of volunteers, religious organizations, social clubs,

and civic and service organizations to support the individual in the community. The lead agency must be held harmless for damages or injuries sustained through the use of volunteers and agencies under this paragraph, including workers' compensation liability.

(c) Approved, written, and signed changes to a consumer's services that meet the criteria in this subdivision shall be an addendum to that consumer's individual service plan.

Sec. 14. Minnesota Statutes 2020, section 256B.0922, subdivision 1, is amended to read:

Subdivision 1. **Essential community supports.** (a) The purpose of the essential community supports program is to provide targeted services to persons age 65 and older who need essential community support, but whose needs do not meet the level of care required for nursing facility placement under section 144.0724, subdivision 11.

(b) Essential community supports are available not to exceed $400 per person per month. Essential community supports may be used as authorized within an authorization period not to exceed 12 months. Services must be available to a person who:

(1) is age 65 or older;

(2) is not eligible for medical assistance;

(3) has received a community assessment under section 256B.0911, ~~subdivision 3a or 3b~~ subdivisions 17 to 21, 23, 24, or 27, and does not require the level of care provided in a nursing facility;

(4) meets the financial eligibility criteria for the alternative care program under section 256B.0913, subdivision 4;

(5) has a community support plan; and

(6) has been determined by a community assessment under section 256B.0911, ~~subdivision 3a or 3b~~ subdivisions 17 to 21, 23, 24 or 27, to be a person who would require provision of at least one of the following services, as defined in the approved elderly waiver plan, in order to maintain their community residence:

(i) adult day services;

(ii) caregiver support;

(iii) homemaker support;

(iv) chores;

(v) a personal emergency response device or system;

(vi) home-delivered meals; or

(vii) community living assistance as defined by the commissioner.

(c) The person receiving any of the essential community supports in this subdivision must also receive service coordination, not to exceed $600 in a 12-month authorization period, as part of their community support plan.

(d) A person who has been determined to be eligible for essential community supports must be reassessed at least annually and continue to meet the criteria in paragraph (b) to remain eligible for essential community supports.

(e) The commissioner is authorized to use federal matching funds for essential community supports as necessary and to meet demand for essential community supports as outlined in subdivision 2, and that amount of federal funds is appropriated to the commissioner for this purpose.

Sec. 15. Minnesota Statutes 2020, section 256B.49, subdivision 12, is amended to read:

Subd. 12. **Informed choice.** Persons who are determined likely to require the level of care provided in a nursing facility as determined under section 256B.0911, subdivision ~~4e~~ 26, or a hospital shall be informed of the home and community-based support alternatives to the provision of inpatient hospital services or nursing facility services. Each person must be given the choice of either institutional or home and community-based services using the provisions described in section 256B.77, subdivision 2, paragraph (p).

Sec. 16. Minnesota Statutes 2020, section 256B.49, subdivision 13, is amended to read:

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

(1) finalizing the person-centered written coordinated service and support plan within the timelines established by the commissioner and section 256B.0911, subdivision ~~3a, paragraph (e)~~ 29;

(2) informing the recipient or the recipient's legal guardian or conservator of service options, including all service options available under the waiver plans;

(3) assisting the recipient in the identification of potential service providers of chosen services, including:

(i) available options for case management service and providers;

(ii) providers of services provided in a non-disability-specific setting;

(iii) employment service providers;

(iv) providers of services provided in settings that are not community residential settings; and

(v) providers of financial management services;

(4) assisting the recipient to access services and assisting with appeals under section 256.045; and

(5) coordinating, evaluating, and monitoring of the services identified in the service plan.

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

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

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

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

(c) Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has any financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision ~~1a, paragraph (e)~~ 10.

(d) For persons who need a positive support transition plan as required in chapter 245D, the case manager shall participate in the development and ongoing evaluation of the plan with the expanded support team. At least quarterly, the case manager, in consultation with the expanded support team, shall evaluate the effectiveness of the plan based on progress evaluation data submitted by the licensed provider to the case manager. The evaluation must identify whether the plan has been developed and implemented in a manner to achieve the following within the required timelines:

(1) phasing out the use of prohibited procedures;

(2) acquisition of skills needed to eliminate the prohibited procedures within the plan's timeline; and

(3) accomplishment of identified outcomes.

If adequate progress is not being made, the case manager shall consult with the person's expanded support team to identify needed modifications and whether additional professional support is required to provide consultation.

(e) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ten hours of case management education and disability-related training each year. The education and training must include person-centered planning. For the purposes of this section, "person-centered planning" or "person-centered" has the meaning given in section 256B.0911, subdivision ~~1a, paragraph (f)~~ 10.

Sec. 17. Minnesota Statutes 2021 Supplement, section 256B.49, subdivision 14, is amended to read:

Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments shall be conducted by certified assessors according to section 256B.0911, ~~subdivision 2b~~ subdivisions 13 and 14.

(b) There must be a determination that the client requires a hospital level of care or a nursing facility level of care as defined in section 256B.0911, subdivision ~~4e~~ 26, at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(c) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only assessments conducted according to section 256B.0911, subdivisions ~~3a, 3b, and 4d~~ 17 to 21, 23, 24, and 27 to 31, that result in a hospital level of care determination or a nursing facility level of care determination must be accepted for purposes of initial and ongoing access to waiver services payment.

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

Sec. 18. Minnesota Statutes 2021 Supplement, section 256B.85, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For the purposes of this section and section 256B.851, the terms defined in this subdivision have the meanings given.

(b) "Activities of daily living" or "ADLs" means:

(1) dressing, including assistance with choosing, applying, and changing clothing and applying special appliances, wraps, or clothing;

(2) grooming, including assistance with basic hair care, oral care, shaving, applying cosmetics and deodorant, and care of eyeglasses and hearing aids. Grooming includes nail care, except for recipients who are diabetic or have poor circulation;

(3) bathing, including assistance with basic personal hygiene and skin care;

(4) eating, including assistance with hand washing and applying orthotics required for eating, transfers, or feeding;

(5) transfers, including assistance with transferring the participant from one seating or reclining area to another;

(6) mobility, including assistance with ambulation and use of a wheelchair. Mobility does not include providing transportation for a participant;

(7) positioning, including assistance with positioning or turning a participant for necessary care and comfort; and

(8) toileting, including assistance with bowel or bladder elimination and care, transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and adjusting clothing.

(c) "Agency-provider model" means a method of CFSS under which a qualified agency provides services and supports through the agency's own employees and policies. The agency must allow the participant to have a significant role in the selection and dismissal of support workers of their choice for the delivery of their specific services and supports.

(d) "Behavior" means a description of a need for services and supports used to determine the home care rating and additional service units. The presence of Level I behavior is used to determine the home care rating.

(e) "Budget model" means a service delivery method of CFSS that allows the use of a service budget and assistance from a financial management services (FMS) provider for a participant to directly employ support workers and purchase supports and goods.

(f) "Complex health-related needs" means an intervention listed in clauses (1) to (8) that has been ordered by a physician, advanced practice registered nurse, or physician's assistant and is specified in a community support plan, including:

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

(ii) continuous tube feeding lasting longer than 12 hours per day;

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

(iii) requiring sterile or clean dressing changes or a wound vac; or

(iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized care;

(3) parenteral therapy described as:

(i) IV therapy more than two times per week lasting longer than four hours for each treatment; or

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

(i) oxygen required more than eight hours per day;

(ii) respiratory vest more than one time per day;

(iii) bronchial drainage treatments more than two times per day;

(iv) sterile or clean suctioning more than six times per day;

(v) dependence on another to apply respiratory ventilation augmentation devices such as BiPAP and CPAP; and

(vi) ventilator dependence under section 256B.0651;

(5) insertion and maintenance of catheter, including:

(i) sterile catheter changes more than one time per month;

(ii) clean intermittent catheterization, and including self-catheterization more than six times per day; or

(iii) bladder irrigations;

(6) bowel program more than two times per week requiring more than 30 minutes to perform each time;

(7) neurological intervention, including:

(i) seizures more than two times per week and requiring significant physical assistance to maintain safety; or

(ii) swallowing disorders diagnosed by a physician, advanced practice registered nurse, or physician's assistant and requiring specialized assistance from another on a daily basis; and

(8) other congenital or acquired diseases creating a need for significantly increased direct hands-on assistance and interventions in six to eight activities of daily living.

(g) "Community first services and supports" or "CFSS" means the assistance and supports program under this section needed for accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task, or the purchase of goods as defined in subdivision 7, clause (3), that replace the need for human assistance.

(h) "Community first services and supports service delivery plan" or "CFSS service delivery plan" means a written document detailing the services and supports chosen by the participant to meet assessed needs that are within the approved CFSS service authorization, as determined in subdivision 8. Services and supports are based on the coordinated service and support plan identified in sections 256B.092, subdivision 1b, and 256S.10.

(i) "Consultation services" means a Minnesota health care program enrolled provider organization that provides assistance to the participant in making informed choices about CFSS services in general and self-directed tasks in particular, and in developing a person-centered CFSS service delivery plan to achieve quality service outcomes.

(j) "Critical activities of daily living" means transferring, mobility, eating, and toileting.

(k) "Dependency" in activities of daily living means a person requires hands-on assistance or constant supervision and cueing to accomplish one or more of the activities of daily living every day or on the days during the week that the activity is performed; however, a child must not be found to be dependent in an activity of daily living if, because of the child's age, an adult would either perform the activity for the child or assist the child with the activity and the assistance needed is the assistance appropriate for a typical child of the same age.

(l) "Extended CFSS" means CFSS services and supports provided under CFSS that are included in the CFSS service delivery plan through one of the home and community-based services waivers and as approved and authorized under chapter 256S and sections 256B.092, subdivision 5, and 256B.49, which exceed the amount, duration, and frequency of the state plan CFSS services for participants. Extended CFSS excludes the purchase of goods.

(m) "Financial management services provider" or "FMS provider" means a qualified organization required for participants using the budget model under subdivision 13 that is an enrolled provider with the department to provide vendor fiscal/employer agent financial management services (FMS).

(n) "Health-related procedures and tasks" means procedures and tasks related to the specific assessed health needs of a participant that can be taught or assigned by a state-licensed health care or mental health professional and performed by a support worker.

(o) "Instrumental activities of daily living" means activities related to living independently in the community, including but not limited to: meal planning, preparation, and cooking; shopping for food, clothing, or other essential items; laundry; housecleaning; assistance with medications; managing finances; communicating needs and preferences during activities; arranging supports; and assistance with traveling around and participating in the community, including traveling to medical appointments. For purposes of this paragraph, traveling includes driving and accompanying the recipient in the recipient's chosen mode of transportation and according to the individual CFSS service delivery plan.

(p) "Lead agency" has the meaning given in section 256B.0911, subdivision ~~1a, paragraph (e)~~ 10.

(q) "Legal representative" means parent of a minor, a court-appointed guardian, or another representative with legal authority to make decisions about services and supports for the participant. Other representatives with legal authority to make decisions include but are not limited to a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

(r) "Level I behavior" means physical aggression toward self or others or destruction of property that requires the immediate response of another person.

(s) "Medication assistance" means providing verbal or visual reminders to take regularly scheduled medication, and includes any of the following supports listed in clauses (1) to (3) and other types of assistance, except that a support worker must not determine medication dose or time for medication or inject medications into veins, muscles, or skin:

(1) under the direction of the participant or the participant's representative, bringing medications to the participant including medications given through a nebulizer, opening a container of previously set-up medications, emptying the container into the participant's hand, opening and giving the medication in the original container to the participant, or bringing to the participant liquids or food to accompany the medication;

(2) organizing medications as directed by the participant or the participant's representative; and

(3) providing verbal or visual reminders to perform regularly scheduled medications.

(t) "Participant" means a person who is eligible for CFSS.

(u) "Participant's representative" means a parent, family member, advocate, or other adult authorized by the participant or participant's legal representative, if any, to serve as a representative in connection with the provision of CFSS. If the participant is unable to assist in the selection of a participant's representative, the legal representative shall appoint one.

(v) "Person-centered planning process" means a process that is directed by the participant to plan for CFSS services and supports.

(w) "Service budget" means the authorized dollar amount used for the budget model or for the purchase of goods.

(x) "Shared services" means the provision of CFSS services by the same CFSS support worker to two or three participants who voluntarily enter into a written agreement to receive services at the same time, in the same setting, and through the same agency-provider or FMS provider.

(y) "Support worker" means a qualified and trained employee of the agency-provider as required by subdivision 11b or of the participant employer under the budget model as required by subdivision 14 who has direct contact with the participant and provides services as specified within the participant's CFSS service delivery plan.

(z) "Unit" means the increment of service based on hours or minutes identified in the service agreement.

(aa) "Vendor fiscal employer agent" means an agency that provides financial management services.

(bb) "Wages and benefits" means the hourly wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance,

long-term care insurance, uniform allowance, contributions to employee retirement accounts, or other forms of employee compensation and benefits.

(cc) "Worker training and development" means services provided according to subdivision 18a for developing workers' skills as required by the participant's individual CFSS service delivery plan that are arranged for or provided by the agency-provider or purchased by the participant employer. These services include training, education, direct observation and supervision, and evaluation and coaching of job skills and tasks, including supervision of health-related tasks or behavioral supports.

Sec. 19. Minnesota Statutes 2021 Supplement, section 256B.85, subdivision 5, is amended to read:

Subd. 5. **Assessment requirements.** (a) The assessment of functional need must:

(1) be conducted by a certified assessor according to the criteria established in section 256B.0911, ~~subdivision 3a~~ subdivisions 17 to 21, 23, 24, and 29 to 31;

(2) be conducted face-to-face, initially and at least annually thereafter, or when there is a significant change in the participant's condition or a change in the need for services and supports, or at the request of the participant when the participant experiences a change in condition or needs a change in the services or supports; and

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

(b) The results of the assessment and any recommendations and authorizations for CFSS must be determined and communicated in writing by the lead agency's assessor as defined in section 256B.0911 to the participant or the participant's representative and chosen CFSS providers within ten business days and must include the participant's right to appeal the assessment under section 256.045, subdivision 3.

(c) The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model. The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model without using the assessment process described in this subdivision. Authorization for a temporary level of CFSS services under the agency-provider model is limited to the time specified by the commissioner, but shall not exceed 45 days. The level of services authorized under this paragraph shall have no bearing on a future authorization. For CFSS services needed beyond the 45-day temporary authorization, the lead agency must conduct an assessment as described in this subdivision and participants must use consultation services to complete their orientation and selection of a service model.

Sec. 20. Minnesota Statutes 2020, section 256S.02, subdivision 15, is amended to read:

Subd. 15. **Lead agency.** "Lead agency" means a county administering long-term care consultation services as defined in section 256B.0911, subdivision ~~1a~~ 10, or a tribe or managed care organization under contract with the commissioner to administer long-term care consultation services as defined in section 256B.0911, subdivision ~~1a~~ 10.

Sec. 21. Minnesota Statutes 2020, section 256S.02, subdivision 20, is amended to read:

Subd. 20. **Nursing facility level of care determination.** "Nursing facility level of care determination" refers to determination of institutional level of care described in section 256B.0911, subdivision ~~4e~~ 26.

Sec. 22. Minnesota Statutes 2021 Supplement, section 256S.05, subdivision 2, is amended to read:

Subd. 2. **Nursing facility level of care determination required.** Notwithstanding other assessments identified in section 144.0724, subdivision 4, only assessments conducted according to section 256B.0911~~, subdivisions 3, 3a, and 3b,~~ that result in a nursing facility level of care determination at initial and subsequent assessments shall be accepted for purposes of a participant's initial and ongoing participation in the elderly waiver and a service provider's access to service payments under this chapter.

Sec. 23. Minnesota Statutes 2020, section 256S.06, subdivision 1, is amended to read:

Subdivision 1. **Initial assessments.** A lead agency shall provide each participant with an initial long-term care consultation assessment of strengths, informal supports, and need for services according to section 256B.0911~~, subdivisions 3, 3a, and 3b~~.

Sec. 24. Minnesota Statutes 2020, section 256S.06, subdivision 2, is amended to read:

Subd. 2. **Annual reassessments.** At least every 12 months, a lead agency shall provide each participant with an annual long-term care consultation reassessment according to section 256B.0911, subdivisions ~~3, 3a, and 3b~~ 22 to 25.

Sec. 25. Minnesota Statutes 2020, section 256S.10, subdivision 2, is amended to read:

Subd. 2. **Plan development timeline.** Within the timelines established by the commissioner and section 256B.0911, subdivision ~~3a, paragraph (c)~~ 29, the case manager must develop with the participant and the participant must sign the participant's individualized written coordinated service and support plan.

Sec. 26. **REVISOR INSTRUCTION.**

(a) The revisor of statutes shall change the term "coordinated service and support plan" and similar terms to "support plan" and similar terms wherever these terms appear in Minnesota Statutes, sections 144G.911, 245A.11, 245D.02, 245D.04, 245D.05, 245D.051, 245D.06, 245D.061, 245D.07, 245D.071, 245D.081, 245D.09, 245D.091, 245D.095, 245D.11, 245D.22, 245D.31, 252.41, 252.42, 252.44, 252.45, 252A.02, 256B.0913, 256B.092, 256B.49, 256B.4911, 256B.4914, 256B.85, 256S.01, 256S.08, 256S.09, 256S.10, 256S.11, and 325F.722. The revisor shall also make necessary grammatical changes related to the change in terms in order to preserve the meaning of the text.

(b) The revisor of statutes shall change the term "community support plan" and similar terms to "assessment summary" and similar terms wherever these terms appear in Minnesota Statutes, sections 245.462, 245.4711, 245.477, 245.4835, 245.4871, 245.4873, 245.4881, 245.4885, 245.4887, 245D.091, 256.975, 256B.0623, 256B.0659, 256B.092, 256B.0922, 256B.4911, 256B.4914, and 256B.85. The revisor shall also make necessary grammatical changes related to the change in terms in order to preserve the meaning of the text.

Sec. 27. **EFFECTIVE DATE.**

Sections 1 to 26 are effective July 1, 2022.

**256B.0911 LONG-TERM CARE CONSULTATION SERVICES.**

Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:

(a) Until additional requirements apply under paragraph (b), "long-term care consultation services" means:

(1) intake for and access to assistance in identifying services needed to maintain an individual in the most inclusive environment;

(2) providing recommendations for and referrals to cost-effective community services that are available to the individual;

(3) development of an individual's person-centered community support plan;

(4) providing information regarding eligibility for Minnesota health care programs;

(5) long-term care consultation assessments conducted according to subdivision 3a, which may be completed in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DDs), regional treatment centers, or the person's current or planned residence;

(6) determination of home and community-based waiver and other service eligibility as required under chapter 256S and sections 256B.0913, 256B.092, and 256B.49, including level of care determination for individuals who need an institutional level of care as determined under subdivision 4e, based on a long-term care consultation assessment and community support plan development, appropriate referrals to obtain necessary diagnostic information, and including an eligibility determination for consumer-directed community supports;

(7) providing recommendations for institutional placement when there are no cost-effective community services available;

(8) providing access to assistance to transition people back to community settings after institutional admission;

(9) providing information about competitive employment, with or without supports, for school-age youth and working-age adults and referrals to the Disability Hub and Disability Benefits 101 to ensure that an informed choice about competitive employment can be made. For the purposes of this subdivision, "competitive employment" means work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting, and for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities;

(10) providing information about independent living to ensure that an informed choice about independent living can be made; and

(11) providing information about self-directed services and supports, including self-directed funding options, to ensure that an informed choice about self-directed options can be made.

(b) Upon statewide implementation of lead agency requirements in subdivisions 2b, 2c, and 3a, "long-term care consultation services" also means:

(1) service eligibility determination for the following state plan services:

(i) personal care assistance services under section 256B.0625, subdivisions 19a and 19c;

(ii) consumer support grants under section 256.476; or

(iii) community first services and supports under section 256B.85;

(2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024, gaining access to:

(i) relocation targeted case management services available under section 256B.0621, subdivision 2, clause (4);

(ii) case management services targeted to vulnerable adults or developmental disabilities under section 256B.0924; and

(iii) case management services targeted to people with developmental disabilities under Minnesota Rules, part 9525.0016;

(3) determination of eligibility for semi-independent living services under section 252.275; and

(4) obtaining necessary diagnostic information to determine eligibility under clauses (2) and (3).

(c) "Long-term care options counseling" means the services provided by sections 256.01, subdivision 24, and 256.975, subdivision 7, and also includes telephone assistance and follow up once a long-term care consultation assessment has been completed.

(d) "Minnesota health care programs" means the medical assistance program under this chapter and the alternative care program under section 256B.0913.

(e) "Lead agencies" means counties administering or tribes and health plans under contract with the commissioner to administer long-term care consultation services.

(f) "Person-centered planning" is a process that includes the active participation of a person in the planning of the person's services, including in making meaningful and informed choices about the person's own goals, talents, and objectives, as well as making meaningful and informed choices about the services the person receives, the settings in which the person receives the services, and the setting in which the person lives.

(g) "Informed choice" has the meaning given in section 256B.4905, subdivision 1a.

(h) "Available service and setting options" or "available options," with respect to the home and community-based waivers under chapter 256S and sections 256B.092 and 256B.49, means all services and settings defined under the waiver plan for which a waiver applicant or waiver participant is eligible.

(i) "Independent living" means living in a setting that is not controlled by a provider.

Subd. 2b. **MnCHOICES certified assessors.** (a) Each lead agency shall use certified assessors who have completed MnCHOICES training and the certification processes determined by the commissioner in subdivision 2c. Certified assessors shall demonstrate best practices in assessment and support planning including person-centered planning principles and have a common set of skills that must ensure consistency and equitable access to services statewide. A lead agency may choose, according to departmental policies, to contract with a qualified, certified assessor to conduct assessments and reassessments on behalf of the lead agency. Certified assessors must use person-centered planning principles to conduct an interview that identifies what is important to the person, the person's needs for supports, health and safety concerns, and the person's abilities, interests, and goals.

Certified assessors are responsible for:

(1) ensuring persons are offered objective, unbiased access to resources;

(2) ensuring persons have the needed information to support informed choice, including where and how they choose to live and the opportunity to pursue desired employment;

(3) determining level of care and eligibility for long-term services and supports;

(4) using the information gathered from the interview to develop a person-centered community support plan that reflects identified needs and support options within the context of values, interests, and goals important to the person; and

(5) providing the person with a community support plan that summarizes the person's assessment findings, support options, and agreed-upon next steps.

(b) MnCHOICES certified assessors are persons with a minimum of a bachelor's degree in social work, nursing with a public health nursing certificate, or other closely related field with at least one year of home and community-based experience, or a registered nurse with at least two years of home and community-based experience who has received training and certification specific to assessment and consultation for long-term care services in the state.

Subd. 2c. **Assessor training and certification.** The commissioner shall develop and implement a curriculum and an assessor certification process. All existing lead agency staff designated to provide the services defined in subdivision 1a must be certified within timelines specified by the commissioner, but no sooner than six months after statewide availability of the training and certification process. The commissioner must establish the timelines for training and certification in a manner that allows lead agencies to most efficiently adopt the automated process established in subdivision 5. Each lead agency is required to ensure that they have sufficient numbers of certified assessors to provide long-term consultation assessment and support planning within the timelines and parameters of the service. Certified assessors are required to be recertified every three years.

Subd. 3. **Long-term care consultation team.** (a) A long-term care consultation team shall be established by the county board of commissioners. Two or more counties may collaborate to establish a joint local consultation team or teams.

(b) Each lead agency shall establish and maintain a team of certified assessors qualified under subdivision 2b, paragraph (b). Each team member is responsible for providing consultation with other team members upon request. The team is responsible for providing long-term care consultation services to all persons located in the county who request the services, regardless of eligibility for Minnesota health care programs. The team of certified assessors must include, at a minimum:

(1) a social worker; and

(2) a public health nurse or registered nurse.

(c) The commissioner shall allow arrangements and make recommendations that encourage counties and tribes to collaborate to establish joint local long-term care consultation teams to ensure that long-term care consultations are done within the timelines and parameters of the service. This includes integrated service models as required in subdivision 1, paragraph (b).

(d) Tribes and health plans under contract with the commissioner must provide long-term care consultation services as specified in the contract.

(e) The lead agency must provide the commissioner with an administrative contact for communication purposes.

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons who need assessment in order to determine waiver or alternative care program eligibility, must be visited by a long-term care consultation team within 20 calendar days after the date on which an assessment was requested or recommended. Upon statewide implementation of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person requesting personal care assistance services. The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of this requirement. Assessments must be conducted according to paragraphs (b) to (r).

(b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified assessors to conduct the assessment. For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

(c) The MnCHOICES assessment provided by the commissioner to lead agencies must be used to complete a comprehensive, conversation-based, person-centered assessment. The assessment must include the health, psychological, functional, environmental, and social needs of the individual necessary to develop a person-centered community support plan that meets the individual's needs and preferences.

(d) Except as provided in paragraph (r), the assessment must be conducted by a certified assessor in a face-to-face conversational interview with the person being assessed. The person's legal representative must provide input during the assessment process and may do so remotely if requested. At the request of the person, other individuals may participate in the assessment to provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety. Except for legal representatives or family members invited by the person, persons participating in the assessment may not be a provider of service or have any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living or adult day services under chapter 256S, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment. For a person who is to be assessed for waiver services under section 256B.092 or 256B.49, with the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs the person completed in consultation with someone who is known to the person and has interaction with the person on a regular basis. The provider must submit the report at least 60 days before the end of the person's current service agreement. The certified assessor must consider the content of the submitted report prior to finalizing the person's assessment or reassessment.

(e) The certified assessor and the individual responsible for developing the coordinated service and support plan must complete the community support plan and the coordinated service and support

plan no more than 60 calendar days from the assessment visit. The person or the person's legal representative must be provided with a written community support plan within the timelines established by the commissioner, regardless of whether the person is eligible for Minnesota health care programs.

(f) For a person being assessed for elderly waiver services under chapter 256S, a provider who submitted information under paragraph (d) shall receive the final written community support plan when available and the Residential Services Workbook.

(g) The written community support plan must include:

(1) a summary of assessed needs as defined in paragraphs (c) and (d);

(2) the individual's options and choices to meet identified needs, including:

(i) all available options for case management services and providers;

(ii) all available options for employment services, settings, and providers;

(iii) all available options for living arrangements;

(iv) all available options for self-directed services and supports, including self-directed budget options; and

(v) service provided in a non-disability-specific setting;

(3) identification of health and safety risks and how those risks will be addressed, including personal risk management strategies;

(4) referral information; and

(5) informal caregiver supports, if applicable.

For a person determined eligible for state plan home care under subdivision 1a, paragraph (b), clause (1), the person or person's representative must also receive a copy of the home care service plan developed by the certified assessor.

(h) A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to long-term care options counseling services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(i) The person has the right to make the final decision:

(1) between institutional placement and community placement after the recommendations have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d);

(2) between community placement in a setting controlled by a provider and living independently in a setting not controlled by a provider;

(3) between day services and employment services; and

(4) regarding available options for self-directed services and supports, including self-directed funding options.

(j) The lead agency must give the person receiving long-term care consultation services or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and living arrangements that cost the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under chapter 256S or section 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program;

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects nursing facility placement. If the individual selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and screening for developmental

disability and mental illness collected during the assessment to the long-term care options counselor using forms provided by the commissioner;

(4) the role of long-term care consultation assessment and support planning in eligibility determination for waiver and alternative care programs, and state plan home care, case management, and other services as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(5) information about Minnesota health care programs;

(6) the person's freedom to accept or reject the recommendations of the team;

(7) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;

(8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in subdivision 4e and the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and (8), and (b), and incorporating the decision regarding the need for institutional level of care or the lead agency's final decisions regarding public programs eligibility according to section 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right to the person and must visually point out where in the document the right to appeal is stated; and

(10) documentation that available options for employment services, independent living, and self-directed services and supports were described to the individual.

(k) An assessment that is completed as part of an eligibility determination for multiple programs for the alternative care, elderly waiver, developmental disabilities, community access for disability inclusion, community alternative care, and brain injury waiver programs under chapter 256S and sections 256B.0913, 256B.092, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of the assessment.

(l) The effective eligibility start date for programs in paragraph (k) can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated and documented in the department's Medicaid Management Information System (MMIS). Notwithstanding retroactive medical assistance coverage of state plan services, the effective date of eligibility for programs included in paragraph (k) cannot be prior to the date the most recent updated assessment is completed.

(m) If an eligibility update is completed within 90 days of the previous assessment and documented in the department's Medicaid Management Information System (MMIS), the effective date of eligibility for programs included in paragraph (k) is the date of the previous face-to-face assessment when all other eligibility requirements are met.

(n) If a person who receives home and community-based waiver services under section 256B.0913, 256B.092, or 256B.49 or chapter 256S temporarily enters for 121 days or fewer a hospital, institution of mental disease, nursing facility, intensive residential treatment services program, transitional care unit, or inpatient substance use disorder treatment setting, the person may return to the community with home and community-based waiver services under the same waiver, without requiring an assessment or reassessment under this section, unless the person's annual reassessment is otherwise due. Nothing in this paragraph shall change annual long-term care consultation reassessment requirements, payment for institutional or treatment services, medical assistance financial eligibility, or any other law.

(o) At the time of reassessment, the certified assessor shall assess each person receiving waiver residential supports and services currently residing in a community residential setting, licensed adult foster care home that is either not the primary residence of the license holder or in which the license holder is not the primary caregiver, family adult foster care residence, customized living setting, or supervised living facility to determine if that person would prefer to be served in a community-living setting as defined in section 256B.49, subdivision 23, in a setting not controlled by a provider, or to receive integrated community supports as described in section 245D.03, subdivision 1, paragraph (c), clause (8). The certified assessor shall offer the person, through a person-centered planning process, the option to receive alternative housing and service options.

(p) At the time of reassessment, the certified assessor shall assess each person receiving waiver day services to determine if that person would prefer to receive employment services as described in section 245D.03, subdivision 1, paragraph (c), clauses (5) to (7). The certified assessor shall describe to the person through a person-centered planning process the option to receive employment services.

(q) At the time of reassessment, the certified assessor shall assess each person receiving non-self-directed waiver services to determine if that person would prefer an available service and setting option that would permit self-directed services and supports. The certified assessor shall describe to the person through a person-centered planning process the option to receive self-directed services and supports.

(r) All assessments performed according to this subdivision must be face-to-face unless the assessment is a reassessment meeting the requirements of this paragraph. Remote reassessments conducted by interactive video or telephone may substitute for face-to-face reassessments. For services provided by the developmental disabilities waiver under section 256B.092, and the community access for disability inclusion, community alternative care, and brain injury waiver programs under section 256B.49, remote reassessments may be substituted for two consecutive reassessments if followed by a face-to-face reassessment. For services provided by alternative care under section 256B.0913, essential community supports under section 256B.0922, and the elderly waiver under chapter 256S, remote reassessments may be substituted for one reassessment if followed by a face-to-face reassessment. A remote reassessment is permitted only if the person being reassessed, or the person's legal representative, and the lead agency case manager both agree that there is no change in the person's condition, there is no need for a change in service, and that a remote reassessment is appropriate. The person being reassessed, or the person's legal representative, has the right to refuse a remote reassessment at any time. During a remote reassessment, if the certified assessor determines a face-to-face reassessment is necessary in order to complete the assessment, the lead agency shall schedule a face-to-face reassessment. All other requirements of a face-to-face reassessment shall apply to a remote reassessment, including updates to a person's support plan.

Subd. 3b. **Transition assistance.** (a) Lead agency certified assessors shall provide assistance to persons residing in a nursing facility, hospital, regional treatment center, or intermediate care facility for persons with developmental disabilities who request or are referred for assistance. Transition assistance must include assessment, community support plan development, referrals to long-term care options counseling under section 256.975, subdivision 7, for community support plan implementation and to Minnesota health care programs, including home and community-based waiver services and consumer-directed options through the waivers, and referrals to programs that provide assistance with housing. Transition assistance must also include information about the Centers for Independent Living, Disability Hub, and about other organizations that can provide assistance with relocation efforts, and information about contacting these organizations to obtain their assistance and support.

(b) The lead agency shall ensure that:

(1) referrals for in-person assessments are taken from long-term care options counselors as provided for in section 256.975, subdivision 7, paragraph (b), clause (11);

(2) persons assessed in institutions receive information about transition assistance that is available;

(3) the assessment is completed for persons within 20 calendar days of the date of request or recommendation for assessment;

(4) there is a plan for transition and follow-up for the individual's return to the community, including notification of other local agencies when a person may require assistance from agencies located in another county; and

(5) relocation targeted case management as defined in section 256B.0621, subdivision 2, clause (4), is authorized for an eligible medical assistance recipient.

Subd. 3f. **Long-term care reassessments and community support plan updates.** (a) Prior to a reassessment, the certified assessor must review the person's most recent assessment. Reassessments must be tailored using the professional judgment of the assessor to the person's known needs, strengths, preferences, and circumstances. Reassessments provide information to support the person's informed choice and opportunities to express choice regarding activities that contribute to quality of life, as well as information and opportunity to identify goals related to desired employment,

community activities, and preferred living environment. Reassessments require a review of the most recent assessment, review of the current coordinated service and support plan's effectiveness, monitoring of services, and the development of an updated person-centered community support plan. Reassessments must verify continued eligibility, offer alternatives as warranted, and provide an opportunity for quality assurance of service delivery. Reassessments must be conducted annually or as required by federal and state laws and rules. For reassessments, the certified assessor and the individual responsible for developing the coordinated service and support plan must ensure the continuity of care for the person receiving services and complete the updated community support plan and the updated coordinated service and support plan no more than 60 days from the reassessment visit.

(b) The commissioner shall develop mechanisms for providers and case managers to share information with the assessor to facilitate a reassessment and support planning process tailored to the person's current needs and preferences.

Subd. 3g. **Assessments for Rule 185 case management.** Unless otherwise required by federal law, the county agency is not required to conduct or arrange for an annual needs reassessment by a certified assessor. The case manager who works on behalf of the person to identify the person's needs and to minimize the impact of the disability on the person's life must instead develop a person-centered service plan based on the person's assessed needs and preferences. The person-centered service plan must be reviewed annually for persons with developmental disabilities who are receiving only case management services under Minnesota Rules, part 9525.0016, and who make an informed choice to decline an assessment under this section.

Subd. 4d. **Preadmission screening of individuals under 65 years of age.** (a) It is the policy of the state of Minnesota to ensure that individuals with disabilities or chronic illness are served in the most integrated setting appropriate to their needs and have the necessary information to make informed choices about home and community-based service options.

(b) Individuals under 65 years of age who are admitted to a Medicaid-certified nursing facility must be screened prior to admission according to the requirements outlined in section 256.975, subdivisions 7a to 7c. This shall be provided by the Senior LinkAge Line as required under section 256.975, subdivision 7.

(c) Individuals under 65 years of age who are admitted to nursing facilities with only a telephone screening must receive a face-to-face assessment from the long-term care consultation team member of the county in which the facility is located or from the recipient's county case manager within the timeline established by the commissioner, based on review of data.

(d) At the face-to-face assessment, the long-term care consultation team member or county case manager must perform the activities required under subdivision 3b.

(e) For individuals under 21 years of age, a screening interview which recommends nursing facility admission must be face-to-face and approved by the commissioner before the individual is admitted to the nursing facility.

(f) In the event that an individual under 65 years of age is admitted to a nursing facility on an emergency basis, the Senior LinkAge Line must be notified of the admission on the next working day, and a face-to-face assessment as described in paragraph (c) must be conducted within the timeline established by the commissioner, based on review of data.

(g) At the face-to-face assessment, the long-term care consultation team member or the case manager must present information about home and community-based options, including consumer-directed options, so the individual can make informed choices. If the individual chooses home and community-based services, the long-term care consultation team member or case manager must complete a written relocation plan within 20 working days of the visit. The plan shall describe the services needed to move out of the facility and a time line for the move which is designed to ensure a smooth transition to the individual's home and community.

(h) An individual under 65 years of age residing in a nursing facility shall receive a face-to-face assessment at least every 12 months to review the person's service choices and available alternatives unless the individual indicates, in writing, that annual visits are not desired. In this case, the individual must receive a face-to-face assessment at least once every 36 months for the same purposes.

(i) Notwithstanding the provisions of subdivision 6, the commissioner may pay county agencies directly for face-to-face assessments for individuals under 65 years of age who are being considered for placement or residing in a nursing facility.

(j) Funding for preadmission screening follow-up shall be provided to the Disability Hub for the under-60 population by the Department of Human Services to cover options counseling salaries and expenses to provide the services described in subdivisions 7a to 7c. The Disability Hub shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide preadmission screening follow-up services and shall seek to maximize federal funding for the service as provided under section 256.01, subdivision 2, paragraph (aa).

Subd. 4e. **Determination of institutional level of care.** The determination of the need for nursing facility, hospital, and intermediate care facility levels of care must be made according to criteria developed by the commissioner, and in section 256B.092, using forms developed by the commissioner. Effective January 1, 2014, for individuals age 21 and older, the determination of need for nursing facility level of care shall be based on criteria in section 144.0724, subdivision 11. For individuals under age 21, the determination of the need for nursing facility level of care must be made according to criteria developed by the commissioner until criteria in section 144.0724, subdivision 11, becomes effective on or after October 1, 2019.

Subd. 5. **Administrative activity.** (a) The commissioner shall streamline the processes, including timelines for when assessments need to be completed, required to provide the services in this section and shall implement integrated solutions to automate the business processes to the extent necessary for community support plan approval, reimbursement, program planning, evaluation, and policy development.

(b) The commissioner of human services shall work with lead agencies responsible for conducting long-term consultation services to modify the MnCHOICES application and assessment policies to create efficiencies while ensuring federal compliance with medical assistance and long-term services and supports eligibility criteria.

(c) The commissioner shall work with lead agencies responsible for conducting long-term consultation services to develop a set of measurable benchmarks sufficient to demonstrate quarterly improvement in the average time per assessment and other mutually agreed upon measures of increasing efficiency. The commissioner shall collect data on these benchmarks and provide to the lead agencies and the chairs and ranking minority members of the legislative committees with jurisdiction over human services an annual trend analysis of the data in order to demonstrate the commissioner's compliance with the requirements of this subdivision.

Subd. 6. **Payment for long-term care consultation services.** (a) Until September 30, 2013, payment for long-term care consultation face-to-face assessment shall be made as described in this subdivision.

(b) The total payment for each county must be paid monthly by certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year must be determined by dividing the county's annual allocation for long-term care consultation services by 12 to determine the monthly payment and allocating the monthly payment to each nursing facility based on the number of licensed beds in the nursing facility. Payments to counties in which there is no certified nursing facility must be made by increasing the payment rate of the two facilities located nearest to the county seat.

(c) The commissioner shall include the total annual payment determined under paragraph (b) for each nursing facility reimbursed under section 256B.431 or 256B.434 or chapter 256R.

(d) In the event of the layaway, delicensure and decertification, or removal from layaway of 25 percent or more of the beds in a facility, the commissioner may adjust the per diem payment amount in paragraph (c) and may adjust the monthly payment amount in paragraph (b). The effective date of an adjustment made under this paragraph shall be on or after the first day of the month following the effective date of the layaway, delicensure and decertification, or removal from layaway.

(e) Payments for long-term care consultation services are available to the county or counties to cover staff salaries and expenses to provide the services described in subdivision 1a. The county shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide long-term care consultation services while meeting the state's long-term care outcomes and objectives as defined in subdivision 1. The county shall be accountable for meeting local objectives as approved by the commissioner in the biennial home and community-based services quality assurance plan on a form provided by the commissioner.

(f) Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.

(g) The commissioner of human services shall amend the Minnesota medical assistance plan to include reimbursement for the local consultation teams.

(h) Until the alternative payment methodology in paragraph (i) is implemented, the county may bill, as case management services, assessments, support planning, and follow-along provided to persons determined to be eligible for case management under Minnesota health care programs. No individual or family member shall be charged for an initial assessment or initial support plan development provided under subdivision 3a or 3b.

(i) The commissioner shall develop an alternative payment methodology, effective on October 1, 2013, for long-term care consultation services that includes the funding available under this subdivision, and for assessments authorized under sections 256B.092 and 256B.0659. In developing the new payment methodology, the commissioner shall consider the maximization of other funding sources, including federal administrative reimbursement through federal financial participation funding, for all long-term care consultation activity. The alternative payment methodology shall include the use of the appropriate time studies and the state financing of nonfederal share as part of the state's medical assistance program. Between July 1, 2017, and June 30, 2019, the state shall pay 84.3 percent of the nonfederal share as reimbursement to the counties. Beginning July 1, 2019, the state shall pay 81.9 percent of the nonfederal share as reimbursement to the counties.