DHS Hearing Testimony – AL Licensure 12/14/2022

1. Introduction
    a. Suzanne Scheller, attorney with Scheller Legal Solutions in the area of elder abuse and neglect.
    b. Also, Legal Advisor for Elder Voice Advocates
    c. As an advocate for residents, I want to support assisted living licensure
2. For the protection and quality of life of Minnesota's 60,000 assisted living residents, we need to remain committed to assisted living licensure. Licensure was developed over time with extensive and broad-based stakeholder discussion.
    a. In 2017, MN was identified as the only state to not license assisted living facilities
    b. 2017 – MDH request for additional funding for maltreatment investigations given a 600% rise in reports of suspected maltreatment over several years.
    c. 2017 Gov. Dayton's Consumer task force findings recommended assisted living licensure
    d. 2018 Office of Legislative Auditor's report recommended assisted living licensure
    e. 2018 – MDH stakeholder group meetings over months in at least six different areas, including AL licensure. Discussions were in person with providers, advocates, state departments and the public. The outcome was the 2019 proposed legislation with assisted living licensure as a cornerstone and other protections.
    f. 2019-2020- MDH engaged in a rulemaking process with an Advisory Board and similar stakeholder input as licensure. Rules were proposed and adopted with public comment and a hearing.
    g. 2020 – COVID revealed the importance of licensure and corresponding MDH input into infection control, visitation guidance, and other important regulatory measures
    h. 8/1/2021 licensure was effective
    i. The road to creating assisted living licensure was well vetted and developed in collaboration.
3. Currently
    a. Assisted living and assisted living with dementia care licenses have been granted to approximately 2,000 providers. Most housing with services registrants applied for AL license, as an indicator of the need for AL facilities and that many made the transition.
    b. Now is not the time to revert and back off of licensure and regulation.
        i. Residents have additional protections under licensure and MDH has the ability to monitor and assess services and physical plant impacts on residents.
        ii. Important termination protections have allowed for continuity of care where possible and a process for termination when necessary.
        iii. Rules were developed to compliment statute, which do not exist in the home care law and allow for greater detailed and tailored direction for long-term care providers and residents alike.
        iv. Important disclosures to residents regarding AL licensure are required, including to the Ombudsman for Long Term Care and Mental Health
4. Review of current licensure requirements is ongoing

a. As with any law, proposals for clarifications and tweaks are necessary and MDH has reached out to both providers and consumers to facilitate ongoing discussions, resulting in legislative proposals. Such MDH proposals are working as intended, to update AL licensure as needed with input from stakeholders.
b. There are two areas that may warrant additional discussion to ensure proper fit, both of which involve DHS:
    i. Approximately 1,000 of the 2,000 AL licenses are for small providers with 5-7 residents. These settings may operate more like HCBS licensed facilities under waivered programs, yet the providers did not seek such license when doing aware with housing with services registration but rather sought out AL licenses. There may be several reasons for that, and further discussion needs to occur to identify concerns and seek solutions. It is possible that more education needs to occur to ensure the proper fit since many of these settings are not primarily designed for elder services, which can be misleading to residents and the public.
    ii. The second area is exempt settings, such as federal housing options, which are not currently licensed. Residents are not afforded protections of licensure when the settings remain unlicensed. We must take care to again identify barriers to licensure and propose solutions.
c. Also, in general, staffing, equitable funding, and equitable pay for invaluable long term care workers needs to be addressed for AL settings to maintain quality services and healthy environments for residents and staff.

5. In conclusion, now is not the time to reverse course in anyway on AL licensure. Additional discussion is likely needed in the areas of small providers, exempt settings, and equitable staff pay and funding, but given the long history of stakeholder engagement to develop AL licensure and the need for consistent offerings and monitoring of licensed settings for the growing elder population, AL license is expected and necessary.