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State of Minnesota
HOUSE OF REPRESENTATIVES
NINETIETH SESSION

H. F. No. 3192

03/01/2018 Authored by Albright
The bill was read for the first time and referred to the Committee on Health and Human Services Reform

1.1 A bill for an act
1.2 relating to human services; modifying assessment timelines for personal care
1.3 assistance services and waived services; eliminating assessments for personal
1.4 care assistance services and developmental disability case management from the
1.5 definition of long-term care consultation services; sunsetting county cost sharing
1.6 for long-term care consultation services; requiring the development of an
1.7 abbreviated MnCHOICES reassessment tool; amending Minnesota Statutes 2016,
1.8 sections 256B.0652, subdivision 8; 256B.0659, subdivision 6, by adding a
1.9 subdivision; 256B.0911, by adding a subdivision; 256B.0915, subdivision 6;
1.10 256B.092, subdivisions 1b, 1g; 256B.49, subdivision 14; Minnesota Statutes 2017
1.11 Supplement, sections 256B.0911, subdivisions 1a, 3a, 3f, 5, 6; 256B.0915,
1.12 subdivision 5; 256B.49, subdivision 13; repealing Minnesota Statutes 2016, section
1.13 256B.0659, subdivision 3a.

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

1.15 Section 1. Minnesota Statutes 2016, section 256B.0652, subdivision 8, is amended to read:

1.16 Subd. 8. **Authorization; time limits; amount and type.** (a) The commissioner or the
1.17 commissioner's designee shall determine the time period for which an authorization shall
1.18 be effective. If the recipient continues to require home care services beyond the duration
1.19 of the authorization, the home care provider must request a new authorization. A personal
1.20 care provider agency must request a new personal care assistance services assessment, or
1.21 service update if allowed, at least 60 days prior to the end of the current authorization time
1.22 period. The request for the assessment must be made on a form approved by the
1.23 commissioner. An authorization must be valid for no more than 12 months.

1.24 (b) The amount and type of personal care assistance services authorized based upon the
1.25 assessment and service plan must remain in effect for the recipient whether the recipient
1.26 chooses a different provider or enrolls or disenrolls from a managed care plan under section

2.1 256B.0659, unless the service needs of the recipient change and new assessment is warranted
2.2 under section 256B.0659, subdivision ~~3a~~ 3b.

2.3 Sec. 2. Minnesota Statutes 2016, section 256B.0659, is amended by adding a subdivision
2.4 to read:

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

2.12 (b) An assessment must include: documentation of health status, determination of need,
2.13 evaluation of service effectiveness, identification of appropriate services, service plan
2.14 development or modification, coordination of services, referrals and follow-up to appropriate
2.15 payers and community resources, completion of required reports, recommendation of service
2.16 authorization, and consumer education. Once the need for personal care assistance services
2.17 is determined under this section, the county public health nurse or certified public health
2.18 nurse under contract with the county is responsible for communicating this recommendation
2.19 to the commissioner and the recipient. An in-person assessment must occur at least annually
2.20 or when there is a significant change in the recipient's condition or when there is a change
2.21 in the recipient's need for personal care assistance services.

2.22 (c) A service update may substitute for the annual in-person assessment when there is
2.23 not a significant change in the recipient's condition or the recipient's need for personal care
2.24 assistance service. A service update may be completed by telephone, used when there is no
2.25 need for an increase in personal care assistance services, and used for two consecutive
2.26 assessments if then followed by an in-person assessment. A service update must be completed
2.27 on a form approved by the commissioner. A service update or review for temporary increase
2.28 must include a review of initial baseline data, evaluation of service effectiveness,
2.29 redetermination of service need, modification of service plan and appropriate referrals,
2.30 update of initial forms, obtaining service authorization, and ongoing consumer education.

2.31 (d) Assessments or reassessments must be completed on forms provided by the
2.32 commissioner within 30 days of a request for home care services by a recipient or responsible
2.33 party.

3.1 Sec. 3. Minnesota Statutes 2016, section 256B.0659, subdivision 6, is amended to read:

3.2 Subd. 6. **Service plan.** The service plan must be completed by the assessor with the
3.3 recipient and responsible party on a form determined by the commissioner and include a
3.4 summary of the assessment with a description of the need, authorized amount, and expected
3.5 outcomes and goals of personal care assistance services. The recipient and the provider
3.6 chosen by the recipient or responsible party must be given a copy of the completed service
3.7 plan within ~~ten~~ 30 working days of the assessment. The recipient or responsible party must
3.8 be given information by the assessor about the options in the personal care assistance program
3.9 to allow for review and decision making.

3.10 Sec. 4. Minnesota Statutes 2017 Supplement, section 256B.0911, subdivision 1a, is
3.11 amended to read:

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

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

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

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

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

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

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

3.24 (6) determination of home and community-based waiver and other service eligibility as
3.25 required under sections 256B.0913, 256B.0915, and 256B.49, including level of care
3.26 determination for individuals who need an institutional level of care as determined under
3.27 subdivision 4e, based on assessment and community support plan development, appropriate
3.28 referrals to obtain necessary diagnostic information, and including an eligibility determination
3.29 for consumer-directed community supports;

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

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

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

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

4.13 (1) ~~service eligibility determination for state plan home care services identified in:~~

4.14 ~~(i) section 256B.0625, subdivisions 7, 19a, and 19e;~~

4.15 ~~(ii) consumer support grants under section 256.476; or~~

4.16 ~~(iii) section 256B.85;~~

4.17 (2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,
4.18 determination of eligibility for case management services available under sections 256B.0621,
4.19 subdivision 2, paragraph clause (4), and 256B.0924 ~~and Minnesota Rules, part 9525.0016;~~

4.20 (3) determination of institutional level of care, home and community-based service
4.21 waiver, and other service eligibility as required under section 256B.092, determination of
4.22 eligibility for family support grants under section 252.32, semi-independent living services
4.23 under section 252.275, and day training and habilitation services under section 256B.092;
4.24 ~~and~~

4.25 (4) obtaining necessary diagnostic information to determine eligibility under clauses (2)
4.26 and (3); and

4.27 (5) notwithstanding Minnesota Rules, parts 9525.0004 to 9525.0024, initial eligibility
4.28 determination for case management services available under Minnesota Rules, part
4.29 9525.0016.

4.30 (c) "Long-term care options counseling" means the services provided by the linkage
4.31 lines as mandated by sections 256.01, subdivision 24, and 256.975, subdivision 7, and also

5.1 includes telephone assistance and follow up once a long-term care consultation assessment
5.2 has been completed.

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

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

5.8 (f) "Person-centered planning" is a process that includes the active participation of a
5.9 person in the planning of the person's services, including in making meaningful and informed
5.10 choices about the person's own goals, talents, and objectives, as well as making meaningful
5.11 and informed choices about the services the person receives. For the purposes of this section,
5.12 "informed choice" means a voluntary choice of services by a person from all available
5.13 service options based on accurate and complete information concerning all available service
5.14 options and concerning the person's own preferences, abilities, goals, and objectives. In
5.15 order for a person to make an informed choice, all available options must be developed and
5.16 presented to the person to empower the person to make decisions.

5.17 Sec. 5. Minnesota Statutes 2017 Supplement, section 256B.0911, subdivision 3a, is
5.18 amended to read:

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

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

5.31 (c) The MnCHOICES assessment provided by the commissioner to lead agencies must
5.32 be used to complete a comprehensive, person-centered assessment. The assessment must
5.33 include the health, psychological, functional, environmental, and social needs of the

6.1 individual necessary to develop a community support plan that meets the individual's needs
6.2 and preferences.

6.3 (d) The assessment must be conducted in a face-to-face interview with the person being
6.4 assessed and the person's legal representative. At the request of the person, other individuals
6.5 may participate in the assessment to provide information on the needs, strengths, and
6.6 preferences of the person necessary to develop a community support plan that ensures the
6.7 person's health and safety. Except for legal representatives or family members invited by
6.8 the person, persons participating in the assessment may not be a provider of service or have
6.9 any financial interest in the provision of services. For persons who are to be assessed for
6.10 elderly waiver customized living or adult day services under section 256B.0915, with the
6.11 permission of the person being assessed or the person's designated or legal representative,
6.12 the client's current or proposed provider of services may submit a copy of the provider's
6.13 nursing assessment or written report outlining its recommendations regarding the client's
6.14 care needs. The person conducting the assessment must notify the provider of the date by
6.15 which this information is to be submitted. This information shall be provided to the person
6.16 conducting the assessment prior to the assessment. For a person who is to be assessed for
6.17 waiver services under section 256B.092 or 256B.49, with the permission of the person being
6.18 assessed or the person's designated legal representative, the person's current provider of
6.19 services may submit a written report outlining recommendations regarding the person's care
6.20 needs prepared by a direct service employee with at least 20 hours of service to that client.
6.21 The person conducting the assessment or reassessment must notify the provider of the date
6.22 by which this information is to be submitted. This information shall be provided to the
6.23 person conducting the assessment and the person or the person's legal representative, and
6.24 must be considered prior to the finalization of the assessment or reassessment.

6.25 (e) The person or the person's legal representative must be provided with a written
6.26 community support plan within ~~40 calendar~~ 20 working days of the assessment visit,
6.27 regardless of whether the individual is eligible for Minnesota health care programs.

6.28 (f) For a person being assessed for elderly waiver services under section 256B.0915, a
6.29 provider who submitted information under paragraph (d) shall receive the final written
6.30 community support plan when available and the Residential Services Workbook.

6.31 (g) The written community support plan must include:

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

7.1 (2) the individual's options and choices to meet identified needs, including all available
7.2 options for case management services and providers, including service provided in a
7.3 non-disability-specific setting;

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

7.6 (4) referral information; and

7.7 (5) informal caregiver supports, if applicable.

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

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

7.16 (i) The person has the right to make the final decision between institutional placement
7.17 and community placement after the recommendations have been provided, except as provided
7.18 in section 256.975, subdivision 7a, paragraph (d).

7.19 (j) The lead agency must give the person receiving assessment or support planning, or
7.20 the person's legal representative, materials, and forms supplied by the commissioner
7.21 containing the following information:

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

7.24 (2) documentation that the most cost-effective alternatives available were offered to the
7.25 individual. For purposes of this clause, "cost-effective" means community services and
7.26 living arrangements that cost the same as or less than institutional care. For an individual
7.27 found to meet eligibility criteria for home and community-based service programs under
7.28 section 256B.0915 or 256B.49, "cost-effectiveness" has the meaning found in the federally
7.29 approved waiver plan for each program;

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

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

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

8.7 (5) information about Minnesota health care programs;

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

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

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

8.15 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
8.16 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
8.17 (8), and (b), and incorporating the decision regarding the need for institutional level of care
8.18 or the lead agency's final decisions regarding public programs eligibility according to section
8.19 256.045, subdivision 3.

8.20 (k) Face-to-face assessment completed as part of eligibility determination for the
8.21 alternative care, elderly waiver, community access for disability inclusion, community
8.22 alternative care, and brain injury waiver programs under sections 256B.0913, 256B.0915,
8.23 and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after
8.24 the date of assessment.

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

8.32 (m) If an eligibility update is completed within 90 days of the previous face-to-face
8.33 assessment and documented in the department's Medicaid Management Information System

9.1 (MMIS), the effective date of eligibility for programs included in paragraph (k) is the date
9.2 of the previous face-to-face assessment when all other eligibility requirements are met.

9.3 (n) At the time of reassessment, the certified assessor shall assess each person receiving
9.4 waiver services currently residing in a community residential setting, or licensed adult foster
9.5 care home that is not the primary residence of the license holder, or in which the license
9.6 holder is not the primary caregiver, to determine if that person would prefer to be served in
9.7 a community-living setting as defined in section 256B.49, subdivision 23. The certified
9.8 assessor shall offer the person, through a person-centered planning process, the option to
9.9 receive alternative housing and service options.

9.10 Sec. 6. Minnesota Statutes 2017 Supplement, section 256B.0911, subdivision 3f, is amended
9.11 to read:

9.12 Subd. 3f. **Long-term care reassessments and community support plan updates.** (a)
9.13 Reassessments must be tailored using the professional judgment of the assessor to the
9.14 person's known needs, strengths, preferences, and circumstances. Reassessments provide
9.15 information to support the person's informed choice and opportunities to express choice
9.16 regarding activities that contribute to quality of life, as well as information and opportunity
9.17 to identify goals related to desired employment, community activities, and preferred living
9.18 environment. Reassessments allow for a review of the current support plan's effectiveness,
9.19 monitoring of services, and the development of an updated person-centered community
9.20 support plan. Reassessments verify continued eligibility or offer alternatives as warranted
9.21 and provide an opportunity for quality assurance of service delivery. Face-to-face assessments
9.22 reassessments must be conducted annually or as required by federal and state laws and rules.

9.23 (b) A person receiving services identified in subdivision 5, paragraph (d), may elect to
9.24 be reassessed using the abbreviated MnCHOICES reassessment tool developed by the
9.25 commissioner according to subdivision 5, paragraph (d). Lead agencies responsible for
9.26 conducting long-term consultation services must provide a person with sufficient information
9.27 to allow the person to make an informed choice regarding which assessment tool will best
9.28 meet the person's reassessment needs. Lead agencies must make both assessment tools
9.29 available to a person, and may only use the abbreviated MnCHOICES reassessment tool if
9.30 the person makes an informed choice to forgo the comprehensive MnCHOICES assessment
9.31 tool and elects to use the abbreviated MnCHOICES reassessment tool.

10.1 Sec. 7. Minnesota Statutes 2017 Supplement, section 256B.0911, subdivision 5, is amended
10.2 to read:

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

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

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

10.20 (d) The commissioner of human services shall work with lead agencies responsible for
10.21 conducting long-term consultation services to develop an abbreviated MnCHOICES
10.22 reassessment tool as an alternative to the comprehensive MnCHOICES assessment tool
10.23 described in subdivision 3a, paragraph (c). The abbreviated MnCHOICES reassessment
10.24 tool must be sufficient to determine continuing eligibility for the services identified in:

10.25 (1) subdivision 1a, paragraph (a), clause (6), unless the person requires a comprehensive
10.26 reassessment under subdivision 3a, paragraph (n);

10.27 (2) subdivision 1a, paragraph (b); and

10.28 (3) state plan home care services identified in sections 256B.0625, subdivisions 7, 19a,
10.29 and 19c, and 256B.85.

10.30 The abbreviated MnCHOICES reassessment tool must be a simple and efficient tool to
10.31 maintain eligibility for these services while meeting the minimal federal requirements of
10.32 Code of Federal Regulations, title 42, sections 441.301(c)(1) to (3), 441.302(c), 441.351(f),
10.33 441.352(c), 441.466, 441.468, 441.720, and 441.725. The commissioner shall submit any

11.1 state plan and waiver amendments required to implement the abbreviated MnCHOICES
11.2 reassessment tool.

11.3 Sec. 8. Minnesota Statutes 2017 Supplement, section 256B.0911, subdivision 6, is amended
11.4 to read:

11.5 Subd. 6. **Payment for long-term care consultation services.** (a) Until September 30,
11.6 2013, payment for long-term care consultation face-to-face assessment shall be made as
11.7 described in this subdivision.

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

11.15 (c) The commissioner shall include the total annual payment determined under paragraph
11.16 (b) for each nursing facility reimbursed under section 256B.431 or 256B.434 or chapter
11.17 256R.

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

11.24 (e) Payments for long-term care consultation services are available to the county or
11.25 counties to cover staff salaries and expenses to provide the services described in subdivision
11.26 1a. The county shall employ, or contract with other agencies to employ, within the limits
11.27 of available funding, sufficient personnel to provide long-term care consultation services
11.28 while meeting the state's long-term care outcomes and objectives as defined in subdivision
11.29 1. The county shall be accountable for meeting local objectives as approved by the
11.30 commissioner in the biennial home and community-based services quality assurance plan
11.31 on a form provided by the commissioner.

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

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

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

12.8 (i) The commissioner shall develop an alternative payment methodology, effective on
12.9 October 1, 2013, for long-term care consultation services that includes the funding available
12.10 under this subdivision, and for assessments authorized under sections 256B.092 and
12.11 256B.0659. In developing the new payment methodology, the commissioner shall consider
12.12 the maximization of other funding sources, including federal administrative reimbursement
12.13 through federal financial participation funding, for all long-term care consultation activity.
12.14 The alternative payment methodology shall include the use of the appropriate time studies
12.15 and the state financing of nonfederal share as part of the state's medical assistance program.
12.16 ~~Between July 1, 2017, and June 30, 2019, the state shall pay 84.3 percent of the nonfederal~~
12.17 ~~share as reimbursement to the counties. Beginning July 1, 2019, the state shall pay 81.9~~
12.18 ~~percent of the nonfederal share as reimbursement to the counties.~~

12.19 Sec. 9. Minnesota Statutes 2016, section 256B.0911, is amended by adding a subdivision
12.20 to read:

12.21 Subd. 6b. **Temporary county cost share for administering assessments.** Between
12.22 July 1, 2017, and June 30, 2019, the state shall pay 84.3 percent of the nonfederal share as
12.23 reimbursement to the counties. Between July 1, 2019, and July 1, 2020, the state shall pay
12.24 81.9 percent of the nonfederal share as reimbursement to the counties. This subdivision
12.25 expires on July 1, 2020.

12.26 Sec. 10. Minnesota Statutes 2017 Supplement, section 256B.0915, subdivision 5, is
12.27 amended to read:

12.28 Subd. 5. **Assessments and reassessments for waiver clients.** (a) Each client shall
12.29 receive an initial assessment of strengths, informal supports, and need for services in
12.30 accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a client
12.31 served under the elderly waiver must be conducted at least every 12 months. There must
12.32 be a determination that the client requires nursing facility level of care as defined in section

13.1 256B.0911, subdivision 4e, at initial and subsequent assessments to initiate and maintain
13.2 participation in the waiver program.

13.3 (b) Regardless of other assessments identified in section 144.0724, subdivision 4, as
13.4 appropriate to determine nursing facility level of care for purposes of medical assistance
13.5 payment for nursing facility services, only face-to-face assessments conducted according
13.6 to section 256B.0911, subdivisions 3a ~~and~~ 3b, and 3f, that result in a nursing facility level
13.7 of care determination will be accepted for purposes of initial and ongoing access to waiver
13.8 service payment.

13.9 (c) The lead agency shall conduct a change-in-condition reassessment before the annual
13.10 reassessment in cases where a client's condition changed due to a major health event, an
13.11 emerging need or risk, worsening health condition, or cases where the current services do
13.12 not meet the client's needs. A change-in-condition reassessment may be initiated by the lead
13.13 agency, or it may be requested by the client or requested on the client's behalf by another
13.14 party, such as a provider of services. The lead agency shall complete a change-in-condition
13.15 reassessment no later than 20 calendar days from the request. The lead agency shall conduct
13.16 these assessments in a timely manner and expedite urgent requests. The lead agency shall
13.17 evaluate urgent requests based on the client's needs and risk to the client if a reassessment
13.18 is not completed.

13.19 Sec. 11. Minnesota Statutes 2016, section 256B.0915, subdivision 6, is amended to read:

13.20 Subd. 6. **Implementation of coordinated service and support plan.** (a) Each elderly
13.21 waiver client shall be provided a copy of a written coordinated service and support plan
13.22 which:

13.23 (1) is developed and signed by the recipient within ~~ten~~ 30 working days after the case
13.24 manager receives the assessment information and written community support plan as
13.25 described in section 256B.0911, subdivision 3a, from the certified assessor;

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

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

13.30 (4) identifies the person's preferences for services as stated by the person or the person's
13.31 legal guardian or conservator;

14.1 (5) reflects the person's informed choice between institutional and community-based
14.2 services, as well as choice of services, supports, and providers, including available case
14.3 manager providers;

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

14.5 (7) identifies specific services and the amount, frequency, duration, and cost of the
14.6 services to be provided to the person based on assessed needs, preferences, and available
14.7 resources;

14.8 (8) includes information about the right to appeal decisions under section 256.045; and

14.9 (9) includes the authorized annual and estimated monthly amounts for the services.

14.10 (b) In developing the coordinated service and support plan, the case manager should
14.11 also include the use of volunteers, religious organizations, social clubs, and civic and service
14.12 organizations to support the individual in the community. The lead agency must be held
14.13 harmless for damages or injuries sustained through the use of volunteers and agencies under
14.14 this paragraph, including workers' compensation liability.

14.15 Sec. 12. Minnesota Statutes 2016, section 256B.092, subdivision 1b, is amended to read:

14.16 Subd. 1b. **Coordinated service and support plan.** (a) Each recipient of home and
14.17 community-based waived services shall be provided a copy of the written coordinated
14.18 service and support plan which:

14.19 (1) is developed and signed by the recipient within ~~ten~~ 30 working days after the case
14.20 manager receives the assessment information and written community support plan as
14.21 described in section 256B.0911, subdivision 3a, from the certified assessor;

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

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

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

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

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

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

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

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

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

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

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

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

15.18 (b) In developing the coordinated service and support plan, the case manager is
 15.19 encouraged to include the use of volunteers, religious organizations, social clubs, and civic
 15.20 and service organizations to support the individual in the community. The lead agency must
 15.21 be held harmless for damages or injuries sustained through the use of volunteers and agencies
 15.22 under this paragraph, including workers' compensation liability.

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

15.25 Sec. 13. Minnesota Statutes 2016, section 256B.092, subdivision 1g, is amended to read:

15.26 Subd. 1g. **Conditions not requiring development of coordinated service and support**
 15.27 **plan.** (a) Unless otherwise required by federal law, the county agency is not required to
 15.28 complete a coordinated service and support plan as defined in subdivision 1b for:

15.29 (1) persons whose families are requesting respite care for their family member who
 15.30 resides with them, or whose families are requesting a family support grant and are not
 15.31 requesting purchase or arrangement of habilitative services; and

16.1 (2) persons with developmental disabilities, living independently without authorized
16.2 services or receiving funding for services at a rehabilitation facility as defined in section
16.3 268A.01, subdivision 6, and not in need of or requesting additional services.

16.4 (b) Unless otherwise required by federal law, the county agency is not required to (1)
16.5 conduct or arrange for an annual needs reassessment by a certified assessor, (2) develop a
16.6 community support plan according to section 256B.0911, or (3) complete a coordinated
16.7 service and support plan as defined in subdivision 1b. This paragraph applies to persons
16.8 with developmental disabilities who are receiving only case management services under
16.9 Minnesota Rules, parts 9525.0004 to 9525.0036, and who make an informed choice to
16.10 decline an assessment under section 256B.0911.

16.11 Sec. 14. Minnesota Statutes 2017 Supplement, section 256B.49, subdivision 13, is amended
16.12 to read:

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

16.16 (1) finalizing the written coordinated service and support plan within ~~ten~~ 30 working
16.17 days after the case manager receives the plan from the certified assessor;

16.18 (2) informing the recipient or the recipient's legal guardian or conservator of service
16.19 options;

16.20 (3) assisting the recipient in the identification of potential service providers and available
16.21 options for case management service and providers, including services provided in a
16.22 non-disability-specific setting;

16.23 (4) assisting the recipient to access services and assisting with appeals under section
16.24 256.045; and

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

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

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

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

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

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

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

17.16 (1) phasing out the use of prohibited procedures;

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

17.19 (3) accomplishment of identified outcomes.

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

17.23 Sec. 15. Minnesota Statutes 2016, section 256B.49, subdivision 14, is amended to read:

17.24 Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments shall be
17.25 conducted by certified assessors according to section 256B.0911, subdivision 2b. The
17.26 certified assessor, with the permission of the recipient or the recipient's designated legal
17.27 representative, may invite other individuals to attend the assessment. With the permission
17.28 of the recipient or the recipient's designated legal representative, the recipient's current
17.29 provider of services may submit a written report outlining their recommendations regarding
17.30 the recipient's care needs prepared by a direct service employee with at least 20 hours of
17.31 service to that client. The certified assessor must notify the provider of the date by which
17.32 this information is to be submitted. This information shall be provided to the certified

18.1 assessor and the person or the person's legal representative and must be considered prior to
18.2 the finalization of the assessment or reassessment.

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

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

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

18.15 Sec. 16. **REPEALER.**

18.16 Minnesota Statutes 2016, section 256B.0659, subdivision 3a, is repealed.

256B.0659 PERSONAL CARE ASSISTANCE PROGRAM.

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. 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 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.