

This Document can be made available in alternative formats upon request

State of Minnesota

Printed Page No. 168

HOUSE OF REPRESENTATIVES

EIGHTY-EIGHTH SESSION

H. F. No. 841

02/21/2013 Authored by Ward, J.A.; Schoen; Schomacker; Allen; Abeler and others
The bill was read for the first time and referred to the Committee on Health and Human Services Policy
03/21/2013 Adoption of Report: Pass as Amended and Read Second Time
04/25/2013 Calendar for the Day
Read Third Time
Passed by the House and transmitted to the Senate

1.1 A bill for an act
1.2 relating to human services; modifying requirements for assessments; amending
1.3 Minnesota Statutes 2012, section 256B.0911, subdivision 3a.

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

1.5 Section 1. Minnesota Statutes 2012, section 256B.0911, subdivision 3a, is amended to
1.6 read:

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

1.17 (b) The lead agency may utilize a team of either the social worker or public health
1.18 nurse, or both. Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall
1.19 use certified assessors to conduct the assessment. The consultation team members must
1.20 confer regarding the most appropriate care for each individual screened or assessed. For
1.21 a person with complex health care needs, a public health or registered nurse from the
1.22 team must be consulted.

1.23 (c) The assessment must be comprehensive and include a person-centered assessment
1.24 of the health, psychological, functional, environmental, and social needs of referred

2.1 individuals and provide information necessary to develop a community support plan that  
2.2 meets the consumers needs, using an assessment form provided by the commissioner.

2.3 (d) The assessment must be conducted in a face-to-face interview with the person  
2.4 being assessed and the person's legal representative, and other individuals as requested by  
2.5 the person, who can provide information on the needs, strengths, and preferences of the  
2.6 person necessary to develop a community support plan that ensures the person's health and  
2.7 safety, but who is not a provider of service or has any financial interest in the provision  
2.8 of services. For persons who are to be assessed for elderly waiver customized living  
2.9 services under section 256B.0915, with the permission of the person being assessed or  
2.10 the person's designated or legal representative, the client's current or proposed provider  
2.11 of services may submit a copy of the provider's nursing assessment or written report  
2.12 outlining its recommendations regarding the client's care needs. The person conducting  
2.13 the assessment will notify the provider of the date by which this information is to be  
2.14 submitted. This information shall be provided to the person conducting the assessment  
2.15 prior to the assessment.

2.16 (e) If the person chooses to use community-based services, the person or the person's  
2.17 legal representative must be provided with a written community support plan within 40  
2.18 calendar days of the assessment visit, regardless of whether the individual is eligible for  
2.19 Minnesota health care programs. The written community support plan must include:

- 2.20 (1) a summary of assessed needs as defined in paragraphs (c) and (d);  
2.21 (2) the individual's options and choices to meet identified needs, including all  
2.22 available options for case management services and providers;  
2.23 (3) identification of health and safety risks and how those risks will be addressed,  
2.24 including personal risk management strategies;  
2.25 (4) referral information; and  
2.26 (5) informal caregiver supports, if applicable.

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

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

3.1 (g) The person has the right to make the final decision between institutional  
3.2 placement and community placement after the recommendations have been provided,  
3.3 except as provided in subdivision 4a, paragraph (c).

3.4 (h) The lead agency must give the person receiving assessment or support planning,  
3.5 or the person's legal representative, materials, and forms supplied by the commissioner  
3.6 containing the following information:

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

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

3.15 (3) the need for and purpose of preadmission screening if the person selects nursing  
3.16 facility placement;

3.17 (4) the role of long-term care consultation assessment and support planning in  
3.18 eligibility determination for waiver and alternative care programs, and state plan home  
3.19 care, case management, and other services as defined in subdivision 1a, paragraphs (a),  
3.20 clause (7), and (b);

3.21 (5) information about Minnesota health care programs;

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

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

3.25 (8) the certified assessor's decision regarding the person's need for institutional level  
3.26 of care as determined under criteria established in section 256B.0911, subdivision 4a,  
3.27 paragraph (d), and the certified assessor's decision regarding eligibility for all services and  
3.28 programs as defined in subdivision 1a, paragraphs (a), clause (7), and (b); and

3.29 (9) the person's right to appeal the certified assessor's decision regarding eligibility  
3.30 for all services and programs as defined in subdivision 1a, paragraphs (a), clause (7), and  
3.31 (b), and incorporating the decision regarding the need for institutional level of care or the  
3.32 lead agency's final decisions regarding public programs eligibility according to section  
3.33 256.045, subdivision 3.

3.34 (i) Face-to-face assessment completed as part of eligibility determination for  
3.35 the alternative care, elderly waiver, community alternatives for disabled individuals,  
3.36 community alternative care, and brain injury waiver programs under sections 256B.0913,

4.1 256B.0915, and 256B.49 is valid to establish service eligibility for no more than 60  
4.2 calendar days after the date of assessment.

4.3 (j) The effective eligibility start date for programs in paragraph (i) can never be  
4.4 prior to the date of assessment. If an assessment was completed more than 60 days  
4.5 before the effective waiver or alternative care program eligibility start date, assessment  
4.6 and support plan information must be updated ~~in a face-to-face visit~~ and documented in  
4.7 the department's Medicaid Management Information System (MMIS). Notwithstanding  
4.8 retroactive medical assistance coverage of state plan services, the effective date of  
4.9 eligibility for programs included in paragraph (i) cannot be prior to the date the most  
4.10 recent updated assessment is completed.