

SENATE
STATE OF MINNESOTA
NINETY-FIRST SESSION

S.F. No. 3694

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DATE	D-PG	OFFICIAL STATUS
02/27/2020	5028	Introduction and first reading Referred to Human Services Reform Finance and Policy
04/14/2020	5607	Author added Relph
04/23/2020	5822a	Comm report: To pass as amended and re-refer to Finance Joint rule 2.03, referred to Rules and Administration
04/30/2020		Comm report: Adopt previous comm report Jt. rule 2.03 suspended

1.1 A bill for an act

1.2 relating to human services; restoring a requirement for notice to lead agencies

1.3 when MnCHOICES assessments are required for personal care assistance services;

1.4 amending Minnesota Statutes 2019 Supplement, section 256B.0911, subdivision

1.5 3a.

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

1.7 Section 1. Minnesota Statutes 2019 Supplement, section 256B.0911, subdivision 3a, is

1.8 amended to read:

1.9 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services

1.10 planning, or other assistance intended to support community-based living, including persons

1.11 who need assessment in order to determine waiver or alternative care program eligibility,

1.12 must be visited by a long-term care consultation team within 20 calendar days after the date

1.13 on which an assessment was requested or recommended. Upon statewide implementation

1.14 of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person

1.15 requesting personal care assistance services. The commissioner shall provide at least a

1.16 90-day notice to lead agencies prior to the effective date of this requirement. Face-to-face

1.17 assessments must be conducted according to paragraphs (b) to (i).

1.18 (b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified

1.19 assessors to conduct the assessment. For a person with complex health care needs, a public

1.20 health or registered nurse from the team must be consulted.

1.21 (c) The MnCHOICES assessment provided by the commissioner to lead agencies must

1.22 be used to complete a comprehensive, conversation-based, person-centered assessment.

1.23 The assessment must include the health, psychological, functional, environmental, and

2.1 social needs of the individual necessary to develop a community support plan that meets
2.2 the individual's needs and preferences.

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

2.26 (e) The certified assessor and the individual responsible for developing the coordinated
2.27 service and support plan must complete the community support plan and the coordinated
2.28 service and support plan no more than 60 calendar days from the assessment visit. The
2.29 person or the person's legal representative must be provided with a written community
2.30 support plan within the timelines established by the commissioner, regardless of whether
2.31 the person is eligible for Minnesota health care programs.

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

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

- 3.1 (1) a summary of assessed needs as defined in paragraphs (c) and (d);
- 3.2 (2) the individual's options and choices to meet identified needs, including all available
- 3.3 options for case management services and providers, including service provided in a
- 3.4 non-disability-specific setting;
- 3.5 (3) identification of health and safety risks and how those risks will be addressed,
- 3.6 including personal risk management strategies;
- 3.7 (4) referral information; and
- 3.8 (5) informal caregiver supports, if applicable.

3.9 For a person determined eligible for state plan home care under subdivision 1a, paragraph

3.10 (b), clause (1), the person or person's representative must also receive a copy of the home

3.11 care service plan developed by the certified assessor.

3.12 (h) A person may request assistance in identifying community supports without

3.13 participating in a complete assessment. Upon a request for assistance identifying community

3.14 support, the person must be transferred or referred to long-term care options counseling

3.15 services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for

3.16 telephone assistance and follow up.

3.17 (i) The person has the right to make the final decision between institutional placement

3.18 and community placement after the recommendations have been provided, except as provided

3.19 in section 256.975, subdivision 7a, paragraph (d).

3.20 (j) The lead agency must give the person receiving assessment or support planning, or

3.21 the person's legal representative, materials, and forms supplied by the commissioner

3.22 containing the following information:

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

3.24 options;

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

3.26 individual. For purposes of this clause, "cost-effective" means community services and

3.27 living arrangements that cost the same as or less than institutional care. For an individual

3.28 found to meet eligibility criteria for home and community-based service programs under

3.29 chapter 256S or section 256B.49, "cost-effectiveness" has the meaning found in the federally

3.30 approved waiver plan for each program;

3.31 (3) the need for and purpose of preadmission screening conducted by long-term care

3.32 options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects

4.1 nursing facility placement. If the individual selects nursing facility placement, the lead
4.2 agency shall forward information needed to complete the level of care determinations and
4.3 screening for developmental disability and mental illness collected during the assessment
4.4 to the long-term care options counselor using forms provided by the commissioner;

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

4.9 (5) information about Minnesota health care programs;

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

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

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

4.17 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
4.18 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
4.19 (8), and (b), and incorporating the decision regarding the need for institutional level of care
4.20 or the lead agency's final decisions regarding public programs eligibility according to section
4.21 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right
4.22 to the person and must visually point out where in the document the right to appeal is stated.

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

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

5.1 state plan services, the effective date of eligibility for programs included in paragraph (k)
5.2 cannot be prior to the date the most recent updated assessment is completed.

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

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