CHAPTER 63–H.F.No. 767

An act relating to human services; making changes to continuing care provisions; modifying provisions related to advisory task forces, nursing homes, resident relocation, medical assistance, long-term care consultation services, assessments, and reporting of maltreatment; requiring a report; amending Minnesota Statutes 2012, sections 15.014, subdivision 2; 144.0724, subdivision 12; 144A.071, subdivision 4d; 144A.161; 256B.056, subdivision 3; 256B.057, subdivision 9; 256B.0652, subdivision 5; 256B.0659, subdivision 7, by adding a subdivision; 256B.0911, subdivision 3a; 256B.092, subdivision 7; 256B.441, subdivisions 1, 43, 63; 256B.49, subdivision 14; 256B.492; 626.557, subdivision 10; repealing Minnesota Statutes 2012, section 256B.437, subdivision 8; Laws 2012, chapter 216, article 11, section 31.

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

Section 1. Minnesota Statutes 2012, section 15.014, subdivision 2, is amended to read:

Subd. 2. **Creation; limitations.** A commissioner of a state department, a state board or other agency having the powers of a board as defined in section 15.012, may create advisory task forces to advise the commissioner or agency on specific programs or topics within the jurisdiction of the department or agency. A task force so created shall have no more than 15 members. The task force shall expire and the terms and removal of members shall be as provided in section 15.059, subdivision 6. The members of no more than four task forces created pursuant to this section in a department or agency may be paid expenses in the same manner and amount as authorized by the commissioner's plan adopted according to section 43A.18, subdivision 2. Task forces mandated by court order must not be counted for purposes of the limit on the number of task forces whose members may be paid expenses. No member of a task force shall be compensated for services in a manner not provided for in statute. A commissioner, board, council, committee, or other state agency may not create any other multimember agency unless specifically authorized by statute or unless the creation of the agency is authorized by federal law as a condition precedent to the receipt of federal money.

Sec. 2. Minnesota Statutes 2012, section 144.0724, subdivision 12, is amended to read:

Subd. 12. **Appeal of nursing facility level of care determination.** 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), clause ~~(7)~~ (9).

Sec. 3. Minnesota Statutes 2012, section 144A.071, subdivision 4d, is amended to read:

Subd. 4d. **Consolidation of nursing facilities.** (a) The commissioner of health, in consultation with the commissioner of human services, may approve a request for consolidation of nursing facilities which includes the closure of one or more facilities and the upgrading of the physical plant of the remaining nursing facility or facilities, the costs of which exceed the threshold project limit under subdivision 2, clause (a). The commissioners shall consider the criteria in this section, section 144A.073, and section 256B.437, in approving or rejecting a consolidation proposal. In the event the commissioners approve the request, the commissioner of human services shall calculate a property rate adjustment according to clauses (1) to (3):

(1) the closure of beds shall not be eligible for a planned closure rate adjustment under section 256B.437, subdivision 6;

(2) the construction project permitted in this clause shall not be eligible for a threshold project rate adjustment under section 256B.434, subdivision 4f, or a moratorium exception adjustment under section 144A.073; and

(3) the property payment rate for a remaining facility or facilities shall be increased by an amount equal to 65 percent of the projected net cost savings to the state calculated in paragraph (b), divided by the state's medical assistance percentage of medical assistance dollars, and then divided by estimated medical assistance resident days, as determined in paragraph (c), of the remaining nursing facility or facilities in the request in this paragraph. The rate adjustment is effective on the later of the first day of the month following completion of the construction upgrades in the consolidation plan or the first day of the month following the complete closure of a facility designated for closure in the consolidation plan. If more than one facility is receiving upgrades in the consolidation plan, each facility's date of construction completion must be evaluated separately.

(b) For purposes of calculating the net cost savings to the state, the commissioner shall consider clauses (1) to (7):

(1) the annual savings from estimated medical assistance payments from the net number of beds closed taking into consideration only beds that are in active service on the date of the request and that have been in active service for at least three years;

(2) the estimated annual cost of increased case load of individuals receiving services under the elderly waiver;

(3) the estimated annual cost of elderly waiver recipients receiving support under group residential housing;

(4) the estimated annual cost of increased case load of individuals receiving services under the alternative care program;

(5) the annual loss of license surcharge payments on closed beds;

(6) the savings from not paying planned closure rate adjustments that the facilities would otherwise be eligible for under section 256B.437; and

(7) the savings from not paying property payment rate adjustments from submission of renovation costs that would otherwise be eligible as threshold projects under section 256B.434, subdivision 4f.

(c) For purposes of the calculation in paragraph (a), clause (3), the estimated medical assistance resident days of the remaining facility or facilities shall be computed assuming 95 percent occupancy multiplied by the historical percentage of medical assistance resident days of the remaining facility or facilities, as reported on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, multiplied by 365.

(d) For purposes of net cost of savings to the state in paragraph (b), the average occupancy percentages will be those reported on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, and the average payment rates shall be calculated based on the approved payment rates in effect at the time the consolidation request is submitted.

(e) To qualify for the property payment rate adjustment under this provision, the closing facilities shall:

(1) submit an application for closure according to section 256B.437, subdivision 3; and

(2) follow the resident relocation provisions of section 144A.161.

(f) The county or counties in which a facility or facilities are closed under this subdivision shall not be eligible for designation as a hardship area under section 144A.071, subdivision 3, for five years from the date of the approval of the proposed consolidation. The applicant shall notify the county of this limitation and the county shall acknowledge this in a letter of support.

Sec. 4. Minnesota Statutes 2012, section 144A.161, is amended to read:

144A.161 NURSING HOME AND BOARDING CARE HOME RESIDENT RELOCATION.

Subdivision 1. **Definitions.** The definitions in this subdivision apply to subdivisions 2 to 10.

(a) "Change in operations" means any alteration in operations which would require or encourage the relocation of residents.

(b) "Closure" or "closing" means the cessation of operations of a facility ~~and the delicensure and decertification of all beds within the facility~~.

~~(b) "Curtailment," "reduction," or "Change" refers to any change in operations which would result in or encourage the relocation of residents.~~

(c) ~~"Facility" means a nursing home licensed pursuant to this chapter, or a certified boarding care home licensed pursuant to sections 144.50 to 144.56.~~ "Contact information" means name, address, and telephone number and, when available, e-mail address and facsimile number.

~~(d) "Licensee" means the owner of the facility or the owner's designee or the commissioner of health for a facility in receivership.~~

~~(e)~~ (d) "County social services agency" means the county or multicounty social service agency authorized under sections 393.01 and 393.07, as the agency responsible for providing social services for the county in which the ~~nursing home~~ facility is located.

(e) "Facility" means a nursing home licensed pursuant to this chapter, or a boarding care home licensed pursuant to sections 144.50 to 144.56.

(f) "Licensee" means the owner of the facility or the owner's designee or the commissioner of health for a facility in receivership.

~~(f)~~ (g) "Plan" or "relocation plan" means a description of the process developed under subdivision 3, paragraph (b), for the relocation of residents in cases of a facility closure, ~~curtailment,~~ reduction, or change in operations ~~in a facility and the subsequent relocation of residents~~.

(h) "Reduction" means a decrease in the number of beds that would require or encourage the relocation of residents.

~~(g)~~ (i) "Relocation" means the ~~discharge of a resident and~~ movement of the resident to another facility or living arrangement as a result of the closing, ~~curtailment,~~ reduction, or change in operations of a ~~nursing home or boarding care home~~ facility.

(j) "Responsible party" means an individual acting as a legal representative for the resident.

Subd. 1a. **Scope.** Where a facility is undertaking a closure, ~~curtailment,~~ reduction, or change in operations, or where a housing with services unit registered under chapter 144D is closed because the space that it occupies is being replaced by a nursing facility bed that is being reactivated from layaway status, the facility and the county social services agency must comply with the requirements of this section.

Subd. 2. **Initial notice from licensee.** (a) A licensee shall notify the following parties in writing when there is an intent to close ~~or curtail~~, reduce, or change operations ~~which~~ that would ~~result in~~ require or encourage the relocation of residents:

(1) the commissioner of health;

(2) the commissioner of human services;

(3) the county social services agency;

(4) the Office of Ombudsman for Long-Term Care; ~~and~~

(5) the Office of Ombudsman for Mental Health and Developmental Disabilities~~.~~; and

(6) the managed care organizations contracting with Minnesota health care programs within the county where the nursing facility is located.

(b) The written notice shall include the ~~names, telephone numbers, facsimile numbers, and e-mail addresses~~ contact information of the persons in the facility responsible for coordinating the licensee's efforts in the planning process, and the number of residents potentially affected by the closure ~~or curtailment~~, reduction, or change in operations. Only the copy of the notice provided to the county social services agency shall include a complete resident census, including resident name, date of birth, Social Security number, and medical assistance identification number if it is available.

(c) For a facility that is reducing or changing operations, after providing written notice under ~~this section~~ subdivision 5a, and prior to admission, the facility must fully inform prospective residents and their ~~families~~ responsible parties of the intent to ~~close or curtail,~~ reduce~~,~~ or change operations, and of the relocation plan.

(d) A closing facility is prohibited from admitting any new residents on or after the date of the written notice provided under subdivision 5a.

Subd. 3. **Planning process.** (a) The county social services agency shall, within five working days of receiving initial notice of the licensee's intent to close ~~or curtail~~, reduce, or change operations, provide the licensee and all parties identified in subdivision 2, paragraph (a), with the ~~names, telephone numbers, facsimile numbers, and e-mail addresses~~ contact information of those persons responsible for coordinating county social services agency efforts in the planning process.

(b) Within ten working days of receipt of the notice under subdivision 2, paragraph (a), the county social services agency and licensee shall meet to develop the relocation plan. The county social services agency shall inform the ~~Departments~~ Department of Health and the Department of Human Services, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities of the date, time, and location of the meeting so that their representatives may attend. The relocation plan must be completed ~~within~~ no later than 45 days ~~of~~ after receipt of the initial notice in subdivision 2, paragraph (a). ~~However, the plan may be finalized on an earlier schedule agreed to by all parties. To the extent practicable, consistent with requirements to protect the safety and health of residents, the commissioner may authorize the planning process under this subdivision to occur concurrent with the 60-day notice required under subdivision 5a.~~ The plan shall:

(1) identify the expected date of closure, ~~curtailment,~~ reduction, or change in operations;

(2) outline the process for public notification of the closure, ~~curtailment,~~ reduction, or change in operations;

(3) identify efforts that will be made to include other stakeholders in the relocation process;

(4) outline the process to ensure 60-day advance written notice to residents, family members, and designated representatives;

(5) present an aggregate description of the resident population remaining to be relocated and the population's needs;

(6) outline the individual resident assessment process to be utilized;

(7) identify an inventory of available relocation options and resources, including home and community-based services;

~~(8) identify a timeline for submission of the list identified in subdivision 5c, paragraph (b);~~

~~(9)~~ (8) identify a schedule for the timely completion of each element of the plan; ~~and~~

~~(10)~~ (9) identify the steps the licensee and the county social services agency will take to address the relocation needs of individual residents who may be difficult to place due to specialized care needs such as behavioral health problems~~.~~; and

(10) identify the steps needed to share information and coordinate relocation efforts with managed care organizations.

(c) All parties to the plan shall refrain from any public notification of the intent to close ~~or curtail~~, reduce, or change operations until a relocation plan has been established and the notice in subdivision 5a is given. ~~If the planning process occurs concurrently with the 60-day notice period, this requirement does not apply once 60-day notice is given.~~

Subd. 4. **Responsibilities of licensee for resident relocations.** The licensee shall provide for the safe, orderly, and appropriate relocation of residents. The licensee and facility staff shall cooperate with representatives from the county social services agency, the Department of Health, the Department of Human Services, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities in planning for and implementing the relocation of residents.

Subd. 5. **Licensee responsibilities ~~prior~~ related to ~~relocation~~ sending the notice in subdivision 5a.** (a) The licensee shall establish an interdisciplinary team responsible for coordinating and implementing the plan. The interdisciplinary team shall include representatives from the county social services agency, the Office of Ombudsman for Long-Term Care, the Office of the Ombudsman for Mental Health and Developmental Disabilities, facility staff that provide direct care services to the residents, and facility administration.

(b) Concurrent with the notice provided in subdivision 5a, the licensee shall provide ~~a~~ an updated resident census summary document to the county social services agency, the Ombudsman for Long-Term Care, and the Ombudsman for Mental Health and Developmental Disabilities that includes the following information on each resident to be relocated:

(1) resident name;

(2) date of birth;

(3) Social Security number;

(4) payment source and medical assistance identification number, if applicable;

(5) county of financial responsibility if the resident is enrolled in a Minnesota health care program;

(6) date of admission to the facility;

(7) all current diagnoses;

(8) the name of and contact information for the resident's physician;

(9) the name and contact information for the resident's ~~family or other designated representative~~ responsible party;

(10) the ~~names~~ name of and contact information for any case ~~managers~~ manager, managed care coordinator, or other care coordinator, if known; ~~and~~

(11) information on the resident's status related to commitment and probation.; and

(12) the name of the managed care organization in which the resident is enrolled, if known.

(c) The licensee shall consult with the county social services agency on the availability and development of available resources and on the resident relocation process.

Subd. 5a. **Administrator and licensee responsibilities responsibility to provide notice.** At least 60 days before the proposed date of closing, curtailment, reduction, or change in operations as agreed to in the plan, the licensee administrator shall send a written notice of closure or curtailment, reduction, or change in operations to each resident being relocated, the resident's family member or designated representative responsible party, and the resident's managed care organization if it is known, the county social services agency, the commissioner of health, the commissioner of human services, the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, the resident's attending physician, and, in the case of a complete facility closure, the Centers for Medicare and Medicaid Services regional office designated representative. The notice must include the following:

(1) the date of the proposed closure, curtailment, reduction, or change in operations;

(2) the name, address, telephone number, facsimile number, and e-mail address contact information of the individual or individuals in the facility responsible for providing assistance and information;

(3) notification of upcoming meetings for residents, families and designated representatives responsible parties, and resident and family councils to discuss the plan for relocation of residents;

(4) the name, address, and telephone number contact information of the county social services agency contact person; and

(5) the name, address, and telephone number contact information of the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.

The notice must comply with all applicable state and federal requirements for notice of transfer or discharge of nursing home residents.

Subd. 5b. **Licensee responsibility regarding medical information.** The licensee shall request the attending physician provide or arrange for the release of medical information needed to update resident medical records and prepare all required forms and discharge summaries.

Subd. 5c. **Licensee responsibility regarding placement information.** (a) The licensee shall provide sufficient preparation to residents each resident to ensure safe, and orderly, and appropriate discharge and relocation. The licensee shall assist residents each resident in finding placements that respond to personal preferences, such as desired geographic location take into consideration quality, services, location, the resident's needs and choices, and the best interests of each resident.

(b) The licensee shall prepare a resource list with several relocation options for each resident. The list must contain the following information for each relocation option, when applicable:

(1) the name, address, and telephone and facsimile numbers of each facility with appropriate, available beds or services;

(2) the certification level of the available beds;

(3) the types of services available; and

(4) the name, address, and telephone and facsimile numbers of appropriate available home and community-based placements, services, and settings or other options for individuals with special needs.

~~The list shall be made available to residents and their families or designated representatives, and upon request to the Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, and the county social services agency.~~

~~(c) The Senior LinkAge line may make available via a Web site the name, address, and telephone and facsimile numbers of each facility with available beds, the certification level of the available beds, the types of services available, and the number of beds that are available as updated daily by the listed facilities. The licensee must provide residents, their families or designated representatives, the Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, and the county social services agency with the toll-free number and Web site address for the Senior LinkAge line.~~

Subd. 5d. **Licensee responsibility to meet with residents and ~~families~~ responsible parties.** Following the establishment of the plan, the licensee shall conduct meetings with residents, families and ~~designated representatives~~ responsible parties, and resident and family councils to notify them of the process for resident relocation. Representatives from the local county social services agency, the Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, managed care organizations with residents in the facility, the commissioner of health, and the commissioner of human services shall receive advance notice of the meetings.

Subd. 5e. **Licensee responsibility for site visits.** The licensee shall assist residents desiring to make site visits to facilities with available beds or other appropriate living options to which the resident may relocate, unless it is medically inadvisable, as documented by the attending physician in the resident's care record. The licensee shall ~~provide or arrange~~ make available to the resident at no charge transportation for up to three site visits to facilities or other living options within ~~a 50-mile radius to which the resident may relocate, or within a larger radius if no suitable options are available within 50 miles. The licensee shall provide available written materials to residents on a potential new facility or living option~~ the county or contiguous counties.

Subd. 5f. **Licensee ~~responsible~~ responsibility for resident property, funds, and ~~telephone service~~ communication devices.** (a) The licensee shall complete an inventory of resident personal possessions and provide a copy of the final inventory to the resident and the resident's ~~designated representative~~ responsible party prior to relocation. The licensee shall be responsible for the transfer of the resident's possessions ~~for all relocations within a 50-mile radius of the facility, or within a larger radius if no suitable options are available within 50 miles~~ to a selected new location within the county or contiguous counties. The licensee shall complete the transfer of resident possessions in a timely manner~~, but no later than the date of the actual physical relocation of the resident~~.

(b) The licensee shall complete a final accounting of personal funds held in trust by the facility and provide a copy of this accounting to the resident and the resident's ~~family or the resident's designated representative~~ responsible party. The licensee shall be responsible for the transfer of all personal funds held in trust by the facility. The licensee shall complete the transfer of all personal funds in a timely manner.

(c) The licensee shall assist residents with the transfer and reconnection of service for telephones or~~, for residents who are deaf or blind,~~ other personal communication devices or services. The licensee shall pay the costs associated with reestablishing service for telephones or other personal communication devices or services, such as connection fees or other onetime charges. The transfer ~~or~~ and reconnection of personal communication devices or services shall be completed in a timely manner.

Subd. 5g. **Licensee responsibilities for final written discharge notice and records transfer.** (a) The licensee shall provide the resident, the resident's ~~family or designated representative~~ responsible parties, the resident's managed care organization, if known, and the resident's attending physician with a final written discharge notice prior to the relocation of the resident. The notice must:

(1) be provided ~~seven days~~ prior to the actual relocation~~, unless the resident agrees to waive the right to advance notice~~; and

(2) identify the effective date of the anticipated relocation and the destination to which the resident is being relocated.

(b) The licensee shall provide the receiving facility or other health, housing, or care entity with complete and accurate resident records including contact information ~~on~~ for family members, ~~designated representatives~~ responsible parties, ~~guardians,~~ social service or other caseworkers, ~~or other contact information~~ and managed care coordinators. These records must also include all information necessary to provide appropriate medical care and social services. This includes, but is not limited to, information on preadmission screening, Level I and Level II screening, minimum data set (MDS), ~~and~~ all other assessments, current resident diagnoses, social, behavioral, and medication information, required forms, and discharge summaries.

(c) For residents with special care needs, the licensee shall consult with the receiving facility or other placement entity and provide staff training or other preparation as needed to assist in providing for the special needs.

Subd. 6. **Responsibilities of licensee during relocation.** (a) The licensee shall, at no charge to the resident, make arrangements or provide for the transportation of residents to the new facility or ~~placement within a 50-mile radius, or within a larger radius if no suitable options are available within 50 miles~~ location within the county or contiguous counties. The licensee shall provide a staff person to accompany the resident during transportation to the new location within the county or contiguous counties, upon request of the resident, the resident's family, or ~~designated representative~~ responsible party. The discharge and relocation of residents must ~~comply with all applicable state and federal requirements and must~~ be conducted in a safe~~,~~ and orderly~~, and appropriate~~ manner. The licensee must ensure that there is no disruption in providing meals, medications, or treatments of a resident during the relocation process.

(b) Beginning the week following ~~development of the initial relocation plan~~ the announcement in subdivision 5a, the licensee shall submit weekly status reports to the ~~commissioners~~ commissioner of health and the commissioner of human services or their designees, the Ombudsman for Long-Term Care and Ombudsman for Mental Health and Developmental Disabilities, and to the county social services agency. The status reports must be submitted in the format required by the commissioner of health and the commissioner of human services. The initial status report must identify:

(1) the relocation plan developed;

(2) the interdisciplinary team members; and

(3) the number of residents to be relocated.

(c) Subsequent status reports must identify:

(1) any modifications to the plan;

(2) any change of interdisciplinary team members;

(3) the number of residents relocated;

(4) the destination to which residents have been relocated;

(5) the number of residents remaining to be relocated; and

(6) issues or problems encountered during the process and resolution of these issues.

Subd. 7. **Responsibilities of licensee following relocation.** The licensee shall retain or make arrangements for the retention of all remaining resident records for the period required by law. The licensee

shall provide the Department of Health access to these records. The licensee shall notify the Department of Health of the location of any resident records that have not been transferred to the new facility or other health care entity.

Subd. 8. **Responsibilities of county social services agency.** (a) The county social services agency shall participate in the meeting as outlined in subdivision 3, paragraph (b), to develop a relocation plan.

(b) The county social services agency shall designate a representative to the interdisciplinary team established by the licensee responsible for coordinating the relocation efforts.

(c) The county social services agency shall serve as a resource in the relocation process.

(d) Concurrent with the notice sent to residents from the licensee as provided in subdivision 5a, the county social services agency shall provide written notice to residents~~, family, or designated representatives~~ and responsible parties describing:

(1) the county's role in the relocation process and in the follow-up to relocations;

(2) ~~a~~ the county social services agency contact ~~name, address, and telephone number~~ information; and

(3) the ~~name, address, and telephone number of~~ contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.

(e) The county social services agency designee shall meet with appropriate facility staff to coordinate any assistance in the relocation process. This coordination shall include participating in group meetings with residents, families, and ~~designated representatives~~ responsible parties to explain the relocation process.

(f) Beginning from the initial notice given in subdivision 2, the county social services agency shall monitor compliance with all components of this section and the plan developed under subdivision 3, paragraph (b). If the licensee is not in compliance, the county social services agency shall notify the ~~commissioners~~ commissioner of the ~~Departments~~ Department of of Health and the commissioner of the Department of Human Services.

(g) Except as requested by the resident~~, family member, or designated representative~~ or responsible party and within the parameters of the Vulnerable Adults Act, the county social services agency, in coordination with the commissioner of health and the commissioner of human services, may halt a relocation that it deems inappropriate or dangerous to the health or safety of a resident. In situations where a resident relocation is halted, the county social services agency must notify the resident, family, responsible parties, Office of the Ombudsman for Long-Term Care and Office of the Ombudsman for Mental Health and Developmental Disabilities, and resident's managed care organization, of this action. The county social services agency shall pursue remedies to protect the resident during the relocation process, including, but not limited to, assisting the resident with filing an appeal of transfer or discharge, notification of all appropriate licensing boards and agencies, and other remedies available to the county under section 626.557, subdivision 10.

(h) A member of the county social services agency staff shall ~~visit~~ follow up with relocated residents ~~relocated~~ within ~~100 miles of the county within~~ 30 days after the relocation. This requirement does not apply to changes in operation where the facility moved to a new location and residents chose to move to that new location. The requirement also does not apply to residents admitted after the notice ~~of closure~~ in subdivision 5a is given and discharged prior to the actual ~~closure~~ change in facility operations or reduction. County social services agency staff shall interview the resident ~~and family~~ or ~~designated representative, observe the resident on site,~~ responsible party and review and discuss pertinent medical or social records with appropriate facility staff to:

(1) assess the adjustment of the resident to the new placement;

(2) recommend services or methods to meet any special needs of the resident; and

(3) identify residents at risk.

(i) The county social services agency ~~may~~ shall conduct subsequent follow-up visits on-site in cases where the adjustment of the resident to the new placement is in question.

(j) Within 60 days of the completion of the follow-up ~~visits~~ under paragraphs (h) and (i), the county social services agency shall submit a written summary of the follow-up work to the ~~Departments~~ Department of Health and the Department of Human Services in a manner approved by the commissioners.

(k) The county social services agency shall submit to the ~~Departments~~ Department of Health and the Department of Human Services a report of any issues that may require further review or monitoring.

(l) The county social services agency shall be responsible for the safe and orderly relocation of residents in cases where an emergent need arises or when the licensee has abrogated its responsibilities under the plan.

Subd. 9. **Penalties.** Upon the recommendation of the commissioner of health, the commissioner of human services may eliminate a closure rate adjustment under subdivision 10 for violations of this section.

Subd. 10. **Facility closure rate adjustment.** Upon the request of a closing facility, the commissioner of human services must allow the facility a closure rate adjustment equal to a 50 percent payment rate increase to reimburse relocation costs or other costs related to facility closure. This rate increase is effective on the date the facility's occupancy decreases to 90 percent of capacity days after the written notice of closure is distributed under subdivision 5 and shall remain in effect for a period of up to 60 days. The commissioner shall delay the implementation of rate adjustments under section 256B.437, subdivisions 3, paragraph (b), and 6, paragraph (a), to offset the cost of this rate adjustment.

~~Subd. 11. **County costs.** The commissioner of human services shall allocate up to $450 in total state and federal funds per nursing facility bed that is closing, within the limits of the appropriation specified for this purpose, to be used for relocation costs incurred by counties for resident relocation under this section or planned closures under section 256B.437. To be eligible for this allocation, a county in which a nursing facility closes must provide to the commissioner a detailed statement in a form provided by the commissioner of additional costs, not to exceed $450 in total state and federal funds per bed closed, that are directly incurred related to the county's role in the relocation process.~~

Sec. 5. Minnesota Statutes 2012, section 256B.056, subdivision 3, is amended to read:

Subd. 3. **Asset limitations for individuals and families.** (a) To be eligible for medical assistance, a person must not individually own more than $3,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the household must not own more than $6,000 in assets, plus $200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered;

(3) motor vehicles are excluded to the same extent excluded by the supplemental security income program;

(4) assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses;

(5) for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

(6) when a person enrolled in medical assistance under section 256B.057, subdivision 9, is age 65 or older and has been enrolled during each of the 24 consecutive months before the person's 65th birthday, the assets owned by the person and the person's spouse must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when determining eligibility for medical assistance under section 256B.055, subdivision 7. The income of a spouse of a person enrolled in medical assistance under section 256B.057, subdivision 9, during each of the 24 consecutive months before the person's 65th birthday must be disregarded when determining eligibility for medical assistance under section 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions in section 256B.059~~. A person whose 65th birthday occurs in 2012 or 2013 is required to have qualified for medical assistance under section 256B.057, subdivision 9, prior to age 65 for at least 20 months in the 24 months prior to reaching age 65~~; and

(7) effective July 1, 2009, certain assets owned by American Indians are excluded as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(b) No asset limit shall apply to persons eligible under section 256B.055, subdivision 15.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 6. Minnesota Statutes 2012, section 256B.057, subdivision 9, is amended to read:

Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for a person who is employed and who:

(1) but for excess earnings or assets, meets the definition of disabled under the Supplemental Security Income program;

(2) meets the asset limits in paragraph (d); and

(3) pays a premium and other obligations under paragraph (e).

(b) For purposes of eligibility, there is a $65 earned income disregard. To be eligible for medical assistance under this subdivision, a person must have more than $65 of earned income. Earned income must have Medicare, Social Security, and applicable state and federal taxes withheld. The person must document earned income tax withholding. Any spousal income or assets shall be disregarded for purposes of eligibility and premium determinations.

(c) After the month of enrollment, a person enrolled in medical assistance under this subdivision who:

(1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician; or

(2) loses employment for reasons not attributable to the enrollee, and is without receipt of earned income may retain eligibility for up to four consecutive months after the month of job loss. To receive a four-month extension, enrollees must verify the medical condition or provide notification of job loss. All other eligibility requirements must be met and the enrollee must pay all calculated premium costs for continued eligibility.

(d) For purposes of determining eligibility under this subdivision, a person's assets must not exceed $20,000, excluding:

(1) all assets excluded under section 256B.056;

(2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, and pension plans;

(3) medical expense accounts set up through the person's employer; and

(4) spousal assets, including spouse's share of jointly held assets.

(e) All enrollees must pay a premium to be eligible for medical assistance under this subdivision, except as provided under clause (5).

(1) An enrollee must pay the greater of a $65 premium or the premium calculated based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines.

(2) Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

(3) All enrollees who receive unearned income must pay five percent of unearned income in addition to the premium amount, except as provided under clause (5).

(4) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

(5) Effective July 1, 2009, American Indians are exempt from paying premiums as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(f) A person's eligibility and premium shall be determined by the local county agency. Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.

(g) Any required premium shall be determined at application and redetermined at the enrollee's six-month income review or when a change in income or household size is reported. Enrollees must report any change in income or household size within ten days of when the change occurs. A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next six-month review.

(h) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.

(i) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. Good cause exists if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to D, are met. Except when an installment agreement

is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

~~(j) The commissioner shall notify enrollees annually beginning at least 24 months before the person's 65th birthday of the medical assistance eligibility rules affecting income, assets, and treatment of a spouse's income and assets that will be applied upon reaching age 65.~~

~~(k)~~ (j) For enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner shall reimburse the enrollee for Medicare part B premiums under section 256B.0625, subdivision 15, paragraph (a).

Sec. 7. Minnesota Statutes 2012, section 256B.0652, subdivision 5, is amended to read:

Subd. 5. **Authorization; private duty nursing services.** (a) All private duty nursing services shall be authorized by the commissioner or the commissioner's designee. Authorization for private duty nursing services shall be based on medical necessity and cost-effectiveness when compared with alternative care options. The commissioner may authorize medically necessary private duty nursing services in quarter-hour units when:

(1) the recipient requires more individual and continuous care than can be provided during a skilled nurse visit; or

(2) the cares are outside of the scope of services that can be provided by a home health aide or personal care assistant.

(b) The commissioner may authorize:

(1) up to two times the average amount of direct care hours provided in nursing facilities statewide for case mix classification "K" as established by the annual cost report submitted to the department by nursing facilities in May 1992;

(2) private duty nursing in combination with other home care services up to the total cost allowed under this subdivision and section 256B.0652, ~~subdivision 6~~ subdivision 7;

(3) up to 16 hours per day if the recipient requires more nursing than the maximum number of direct care hours as established in clause (1) and ~~the recipient meets the hospital admission criteria established under Minnesota Rules, parts 9505.0501 to 9505.0540~~, but for the provision of the nursing services, the recipient would require a hospital level of care as defined in Code of Federal Regulations, title 42, section 440.10.

(c) The commissioner may authorize up to 16 hours per day of medically necessary private duty nursing services or up to 24 hours per day of medically necessary private duty nursing services until such time as the commissioner is able to make a determination of eligibility for recipients who are cooperatively applying for home care services under the community alternative care program developed under section 256B.49, or until it is determined by the appropriate regulatory agency that a health benefit plan is or is not required to pay for appropriate medically necessary health care services. Recipients or their representatives must cooperatively assist the commissioner in obtaining this determination. Recipients who are eligible for the community alternative care program may not receive more hours of nursing under this section and sections 256B.0651, 256B.0653, 256B.0656, and 256B.0659 than would otherwise be authorized under section 256B.49.

Sec. 8. Minnesota Statutes 2012, section 256B.0659, subdivision 7, is amended to read:

Subd. 7. **Personal care assistance care plan.** (a) Each recipient must have a current personal care assistance care plan based on the service plan in subdivision 6 that is developed by the qualified professional with the recipient and responsible party. A copy of the most current personal care assistance care plan is required to be in the recipient's home and in the recipient's file at the provider agency.

(b) The personal care assistance care plan must have the following components:

(1) start and end date of the care plan;

(2) recipient demographic information, including name and telephone number;

(3) emergency numbers, procedures, and a description of measures to address identified safety and vulnerability issues, including a backup staffing plan;

(4) name of responsible party and instructions for contact;

(5) description of the recipient's individualized needs for assistance with activities of daily living, instrumental activities of daily living, health-related tasks, and behaviors; and

(6) dated signatures of recipient or responsible party and qualified professional.

(c) The personal care assistance care plan must have instructions and comments about the recipient's needs for assistance and any special instructions or procedures required, including whether or not the recipient has requested a personal care assistant of the same gender. The month-to-month plan for the use of personal care assistance services is part of the personal care assistance care plan. The personal care assistance care plan must be completed within the first week after start of services with a personal care provider agency and must be updated as needed when there is a change in need for personal care assistance services. A new personal care assistance care plan is required annually at the time of the reassessment.

Sec. 9. Minnesota Statutes 2012, section 256B.0659, is amended by adding a subdivision to read:

Subd. 7a. **Special instructions; gender.** If a recipient requests a personal care assistant of the same gender as the recipient, the personal care assistance agency must make a reasonable effort to fulfill the request.

Sec. 10. Minnesota Statutes 2012, section 256B.0911, subdivision 3a, is amended to read:

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 and private duty nursing. The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of this requirement. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

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

(c) The assessment must be comprehensive and include a person-centered assessment of the health, psychological, functional, environmental, and social needs of referred individuals and provide information necessary to develop a community support plan that meets the consumers needs, using an assessment form provided by the commissioner.

(d) The assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative, and other individuals as requested by the person, who can 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, but who is not a provider of service or has any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living services under section 256B.0915, 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 will 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 prepared by a direct service employee with a least 20 hours of service to that client. The person conducting the assessment or reassessment 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 and the person or the person's legal representative, and must be considered prior to the finalization of the assessment or reassessment.

(e) If the person chooses to use community-based services, the person or the person's legal representative must be provided with a written community support plan within 40 calendar days of the assessment visit, regardless of whether the individual is eligible for Minnesota health care programs. 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 all available options for case management services and providers;

(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.

(f) 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.

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

(h) The lead agency must give the person receiving assessment or support planning, 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 section 256B.0915 or 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 if the person selects nursing facility placement;

(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 (7), 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 section 256B.0911, subdivision 4a, paragraph (d), and the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (7), and (b); and

(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), ~~clause~~ clauses (7), (8), and (9), 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.

(i) Face-to-face assessment completed as part of eligibility determination for the alternative care, elderly waiver, community alternatives for disabled individuals, community alternative care, and brain injury waiver programs under sections 256B.0913, 256B.0915, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment.

(j) The effective eligibility start date for programs in paragraph (i) 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 ~~in a face-to-face visit~~ 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 (i) cannot be prior to the date the most recent updated assessment is completed.

Sec. 11. Minnesota Statutes 2012, section 256B.092, subdivision 7, is amended to read:

Subd. 7. **~~Screening teams~~ Assessments.** (a) Assessments and reassessments shall be conducted by certified assessors according to section 256B.0911, and must incorporate appropriate referrals to determine eligibility for case management under subdivision 1a.

(b) For persons with developmental disabilities, ~~screening teams~~ a certified assessor shall ~~be established which shall~~ evaluate the need for ~~the~~ an institutional level of care ~~provided by residential-based habilitation services, residential services, training and habilitation services, and nursing facility services~~. The ~~evaluation~~ assessment shall address whether home and community-based services are appropriate for persons who are at risk of placement in an intermediate care facility for persons with developmental disabilities, or for whom there is reasonable indication that they might require this level of care. The ~~screening team~~ certified assessor shall make an evaluation of need within ~~60~~ five working days of ~~a request for service by a person with a developmental disability, and within five working days of~~ an emergency admission of a person to an intermediate care facility for persons with developmental disabilities.

~~(b) The screening team shall consist of the case manager for persons with developmental disabilities, the person, the person's legal guardian or conservator, or the parent if the person is a minor, and a qualified developmental disability professional, as defined in Code of Federal Regulations, title 42, section 483.430, as amended through June 3, 1988. The case manager may also act as the qualified developmental disability professional if the case manager meets the federal definition.~~

~~(c) County social service agencies may contract with a public or private agency or individual who is not a service provider for the person for the public guardianship representation required by the screening or individual service planning process. The contract shall be limited to public guardianship representation for the screening and individual service planning activities. The contract shall require compliance with the commissioner's instructions and may be for paid or voluntary services.~~

~~(d) For persons determined to have overriding health care needs and are seeking admission to a nursing facility or an ICF/MR, or seeking access to home and community-based waivered services, a registered nurse must be designated as either the case manager or the qualified developmental disability professional.~~

~~(e) For persons under the jurisdiction of a correctional agency, the case manager must consult with the corrections administrator regarding additional health, safety, and supervision needs.~~

~~(f)~~ (c) The ~~case manager~~ certified assessor, with the concurrence of the person, the person's legal guardian or conservator, or the parent if the person is a minor, may invite other individuals to attend ~~meetings of the screening team~~ the assessment. With the permission of the person being ~~screened~~ assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining their recommendations regarding the person's care needs prepared by a direct service employee with at least 20 hours of service to that client. The ~~screening team~~ assessor must notify the provider of the date by which this information is to be submitted. This information must be provided to the ~~screening team~~ assessor and the person or the person's legal representative and must be considered prior to the finalization of the ~~screening~~ assessment.

~~(g) No member of the screening team shall have any direct or indirect service provider interest in the case.~~

~~(h) Nothing in this section shall be construed as requiring the screening team meeting to be separate from the service planning meeting.~~

Sec. 12. Minnesota Statutes 2012, section 256B.441, subdivision 1, is amended to read:

Subdivision 1. **Rebasing of nursing facility operating payment rates.** (a) The commissioner shall rebase nursing facility operating payment rates to align payments to facilities with the cost of providing care. The rebased operating payment rates shall be calculated using the statistical and cost report filed by each nursing facility for the report period ending one year prior to the rate year.

(b) The new operating payment rates based on this section shall take effect beginning with the rate year beginning October 1, 2008, and shall be phased in over eight rate years through October 1, 2015. For each year of the phase-in, the operating payment rates shall be calculated using the statistical and cost report filed by each nursing facility for the report period ending one year prior to the rate year.

(c) Operating payment rates shall be rebased on October 1, 2016, and every two years after that date.

(d) Each cost reporting year shall begin on October 1 and end on the following September 30. Beginning in ~~2006~~ 2014, a statistical and cost report shall be filed by each nursing facility by ~~January 15~~ February 1. Notice of rates shall be distributed by August 15 and the rates shall go into effect on October 1 for one year.

(e) Effective October 1, 2014, property rates shall be rebased in accordance with section 256B.431 and Minnesota Rules, chapter 9549. The commissioner shall determine what the property payment rate for a nursing facility would be had the facility not had its property rate determined under section 256B.434. The commissioner shall allow nursing facilities to provide information affecting this rate determination that would have been filed annually under Minnesota Rules, chapter 9549, and nursing facilities shall report information necessary to determine allowable debt. The commissioner shall use this information to determine the property payment rate.

Sec. 13. Minnesota Statutes 2012, section 256B.441, subdivision 43, is amended to read:

Subd. 43. **Reporting of statistical and cost information.** (a) Beginning in 2006, all nursing facilities shall provide information annually to the commissioner on a form and in a manner determined by the commissioner. The commissioner may also require nursing facilities to provide statistical and cost information for a subset of the items in the annual report on a semiannual basis. Nursing facilities shall report only costs directly related to the operation of the nursing facility. The facility shall not include costs which are separately reimbursed by residents, medical assistance, or other payors. Allocations of costs from central, affiliated, or corporate office and related organization transactions shall be reported according to section 256B.432. Beginning with the September 30, 2013, reporting year, the commissioner ~~may~~ shall no longer grant to facilities ~~one extension of up to 15 days for the filing of this report if the extension is requested by December 15 and the commissioner determines that the extension will not prevent the commissioner from establishing rates in a timely manner required by law~~ extensions to the filing deadline. The commissioner may separately require facilities to submit in a manner specified by the commissioner documentation of statistical and cost information included in the report to ensure accuracy in establishing payment rates and to perform audit and appeal review functions under this section. Facilities shall retain all records necessary to document statistical and cost information on the report for a period of no less than seven years. The commissioner may amend information in the report according to subdivision 47. The commissioner may reject a report filed by a nursing facility under this section if the commissioner determines that the report has been filed in a form that is incomplete or inaccurate and the information is insufficient to establish accurate payment rates. In the event that a complete report is not submitted in a timely manner, the commissioner shall reduce the reimbursement payments to a nursing facility to 85 percent of amounts due until the information is filed. The release of withheld payments shall be retroactive for no more than 90 days. A nursing facility that does not submit a report or whose report is filed in a timely manner but determined to be incomplete shall be given written notice that a payment reduction is to be implemented and allowed ten days to complete the report prior to any payment reduction. The commissioner may delay the payment withhold under exceptional circumstances to be determined at the sole discretion of the commissioner.

(b) Nursing facilities may, within 12 months of the due date of a statistical and cost report, file an amendment when errors or omissions in the annual statistical and cost report are discovered and an amendment would result in a rate increase of at least 0.15 percent of the statewide weighted average operating payment rate and shall, at any time, file an amendment which would result in a rate reduction of at least 0.15 percent of the statewide weighted average operating payment rate. The commissioner shall make retroactive adjustments to the total payment rate of a nursing facility if an amendment is accepted. Where a retroactive adjustment is to be made as a result of an amended report, audit findings, or other determination of an incorrect payment rate, the commissioner may settle the payment error through a negotiated agreement with the facility and a gross adjustment of the payments to the facility. Retroactive adjustments shall not be applied to private pay residents. An error or omission for purposes of this item does not include a nursing facility's determination that an election between permissible alternatives was not advantageous and should be changed.

(c) If the commissioner determines that a nursing facility knowingly supplied inaccurate or false information or failed to file an amendment to a statistical and cost report that resulted in or would result in an overpayment, the commissioner shall immediately adjust the nursing facility's payment rate and recover the entire overpayment. The commissioner may also terminate the commissioner's agreement with the nursing facility and prosecute under applicable state or federal law.

Sec. 14. Minnesota Statutes 2012, section 256B.441, subdivision 63, is amended to read:

Subd. 63. **Critical access nursing facilities.** (a) The commissioner, in consultation with the commissioner of health, may designate certain nursing facilities as critical access nursing facilities. The designation shall be granted on a competitive basis, within the limits of funds appropriated for this purpose.

(b) The commissioner shall request proposals from nursing facilities every two years. Proposals must be submitted in the form and according to the timelines established by the commissioner. In selecting applicants to designate, the commissioner, in consultation with the commissioner of health, and with input from stakeholders, shall develop criteria designed to preserve access to nursing facility services in isolated areas, rebalance long-term care, and improve quality.

(c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing facilities designated as critical access nursing facilities:

(1) partial rebasing, with operating payment rates being the sum of 60 percent of the operating payment rate determined in accordance with subdivision 54 and 40 percent of the operating payment rate that would have been allowed had the facility not been designated;

(2) enhanced payments for leave days. Notwithstanding section 256B.431, subdivision 2r, upon designation as a critical access nursing facility, the commissioner shall limit payment for leave days to 60 percent of that nursing facility's total payment rate for the involved resident, and shall allow this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 90 percent;

(3) two designated critical access nursing facilities, with up to 100 beds in active service, may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part 4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner of health will consider each waiver request independently based on the criteria under Minnesota Rules, part 4658.0040;

(4) the minimum threshold under section 256B.431, ~~subdivisions 3f, paragraph (a), and 17e~~ subdivision 15, paragraph (e), shall be 40 percent of the amount that would otherwise apply; and

(5) notwithstanding subdivision 58, beginning October 1, 2014, the quality-based rate limits under subdivision 50 shall apply to designated critical access nursing facilities.

(d) Designation of a critical access nursing facility shall be for a period of two years, after which the benefits allowed under paragraph (c) shall be removed. Designated facilities may apply for continued designation.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 15. Minnesota Statutes 2012, 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. The certified assessor, with the permission of the recipient or the recipient's designated legal representative, may invite other individuals to attend the assessment. With the permission of the recipient or the recipient's designated legal representative, the recipient's current provider of services may submit a written report outlining their recommendations

regarding the recipient's care needs prepared by a direct service employee with at least 20 hours of service to that client. The ~~person conducting the assessment or reassessment~~ certified assessor 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~~ certified assessor and the person or the person's legal representative and must be considered prior to the finalization of the assessment or reassessment.

(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 4a, paragraph (d), 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 face-to-face assessments conducted according to section 256B.0911, subdivisions 3a, 3b, and 4d, 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.

(e) The commissioner shall develop criteria to identify recipients whose level of functioning is reasonably expected to improve and reassess these recipients to establish a baseline assessment. Recipients who meet these criteria must have a comprehensive transitional service plan developed under subdivision 15, paragraphs (b) and (c), and be reassessed every six months until there has been no significant change in the recipient's functioning for at least 12 months. After there has been no significant change in the recipient's functioning for at least 12 months, reassessments of the recipient's strengths, informal support systems, and need for services shall be conducted at least every 12 months and at other times when there has been a significant change in the recipient's functioning. Counties, case managers, and service providers are responsible for conducting these reassessments and shall complete the reassessments out of existing funds.

Sec. 16. Minnesota Statutes 2012, section 256B.492, is amended to read:

256B.492 HOME AND COMMUNITY-BASED SETTINGS FOR PEOPLE WITH DISABILITIES.

(a) Individuals receiving services under a home and community-based waiver under section 256B.092 or 256B.49 may receive services in the following settings:

(1) an individual's own home or family home;

(2) a licensed adult foster care or child foster care setting of up to five people; and

(3) community living settings as defined in section 256B.49, subdivision 23, where individuals with disabilities may reside in all of the units in a building of four or fewer units, and no more than the greater of four or 25 percent of the units in a multifamily building of more than four units.

(b) The settings in paragraph (a) must not:

(1) be located in a building that is a publicly or privately operated facility that provides institutional treatment or custodial care;

(2) be located in a building on the grounds of or adjacent to a public or private institution;

(3) be a housing complex designed expressly around an individual's diagnosis or disability;

(4) be segregated based on a disability, either physically or because of setting characteristics, from the larger community; and

(5) have the qualities of an institution which include, but are not limited to: regimented meal and sleep times, limitations on visitors, and lack of privacy. Restrictions agreed to and documented in the person's individual service plan shall not result in a residence having the qualities of an institution as long as the restrictions for the person are not imposed upon others in the same residence and are the least restrictive alternative, imposed for the shortest possible time to meet the person's needs.

(c) The provisions of paragraphs (a) and (b) do not apply to any setting in which individuals receive services under a home and community-based waiver as of July 1, 2012, and the setting does not meet the criteria of this section.

(d) Notwithstanding paragraph (c), a program in Hennepin County established as part of a Hennepin County demonstration project is qualified for the exception allowed under paragraph (c).

(e) The commissioner shall submit an amendment to the waiver plan no later than December 31, 2012.

Sec. 17. Minnesota Statutes 2012, section 626.557, subdivision 10, is amended to read:

Subd. 10. **Duties of county social service agency.** (a) Upon receipt of a report from the common entry point staff, the county social service agency shall immediately assess and offer emergency and continuing protective social services for purposes of preventing further maltreatment and for safeguarding the welfare of the maltreated vulnerable adult. The county shall use a standardized tool made available by the commissioner. The information entered by the county into the standardized tool must be accessible to the Department of Human Services. In cases of suspected sexual abuse, the county social service agency shall immediately arrange for and make available to the vulnerable adult appropriate medical examination and treatment. When necessary in order to protect the vulnerable adult from further harm, the county social service agency shall seek authority to remove the vulnerable adult from the situation in which the maltreatment occurred. The county social service agency may also investigate to determine whether the conditions which resulted in the reported maltreatment place other vulnerable adults in jeopardy of being maltreated and offer protective social services that are called for by its determination.

(b) County social service agencies may enter facilities and inspect and copy records as part of an investigation. The county social service agency has access to not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, that are maintained by facilities to the extent necessary to conduct its investigation. The inquiry is not limited to the written records of the facility, but may include every other available source of information.

(c) When necessary in order to protect a vulnerable adult from serious harm, the county social service agency shall immediately intervene on behalf of that adult to help the family, vulnerable adult, or other interested person by seeking any of the following:

(1) a restraining order or a court order for removal of the perpetrator from the residence of the vulnerable adult pursuant to section 518B.01;

(2) the appointment of a guardian or conservator pursuant to sections 524.5-101 to 524.5-502, or guardianship or conservatorship pursuant to chapter 252A;

(3) replacement of a guardian or conservator suspected of maltreatment and appointment of a suitable person as guardian or conservator, pursuant to sections 524.5-101 to 524.5-502; or

(4) a referral to the prosecuting attorney for possible criminal prosecution of the perpetrator under chapter 609.

The expenses of legal intervention must be paid by the county in the case of indigent persons, under section 524.5-502 and chapter 563.

In proceedings under sections 524.5-101 to 524.5-502, if a suitable relative or other person is not available to petition for guardianship or conservatorship, a county employee shall present the petition with representation by the county attorney. The county shall contract with or arrange for a suitable person or organization to provide ongoing guardianship services. If the county presents evidence to the court exercising probate jurisdiction that it has made a diligent effort and no other suitable person can be found, a county employee may serve as guardian or conservator. The county shall not retaliate against the employee for any action taken on behalf of the ward or protected person even if the action is adverse to the county's interest. Any person retaliated against in violation of this subdivision shall have a cause of action against the county and shall be entitled to reasonable attorney fees and costs of the action if the action is upheld by the court.

Sec. 18. **THIRD-PARTY REIMBURSEMENT FOR LONG-TERM CARE CONSULTATION SERVICES.**

The commissioner of human services shall submit a request within 60 days of final enactment to the federal government to amend the Medicaid cost allocation plan to allow county or tribal agencies to contract with nongovernmental organizations to conduct assessments under Minnesota Statutes, section 256B.0911, and be reimbursed for assessments conducted under contract. Upon federal approval, this shall be incorporated into the alternative payment methodology under Minnesota Statutes, section 256B.0911, subdivision 6, paragraph (h).

Sec. 19. **RECOMMENDATIONS FOR FURTHER CASE MANAGEMENT REDESIGN.**

(a) By February 1, 2014, the commissioner of human services shall develop a legislative report with specific recommendations and language for proposed legislation to:

(1) increase opportunities for choice of case management service provider;

(2) define the service of case management to include the identification of roles and activities of a case manager to avoid duplication of services;

(3) provide guidance on caseload size to reduce variation across the state;

(4) develop a statewide system to standardize case management provider standards, which may include establishing a licensure or certification process;

(5) develop reporting measures to determine outcomes for case management services to increase continuous quality improvement;

(6) establish rates for the service of case management that are transparent and consistent for all medical assistance-paid case management;

(7) develop information for case management recipients to make an informed choice of case management service provider; and

(8) provide waiver case management recipients with an itemized list of case management services provided on a monthly basis.

(b) The commissioner shall consult with existing stakeholder groups which include representatives of counties, tribes, disability and senior advocacy groups including mental health stakeholders, managed care organizations, and service providers in preparing the recommendations and language for proposed legislation. The commissioner shall present findings, recommendations, and proposed legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2014.

Sec. 20. **REPEALER.**

(a) Minnesota Statutes 2012, section 256B.437, subdivision 8, is repealed.

(b) Laws 2012, chapter 216, article 11, section 31, is repealed.

Presented to the governor May 13, 2013

Signed by the governor May 16, 2013, 5:31 p.m.