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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-SECOND SESSION

H. F. No. 4154

03/10/2022

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The bill was read for the first time and referred to the Committee on Human Services Finance and Policy

1.1 A bill for an act

1.2 relating to human services; modifying assessment requirements for customized

1.3 living; amending Minnesota Statutes 2021 Supplement, section 256B.0911,

1.4 subdivision 3a.

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

1.6 Section 1. Minnesota Statutes 2021 Supplement, section 256B.0911, subdivision 3a, is

1.7 amended to read:

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

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

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

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

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

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

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

1.15 90-day notice to lead agencies prior to the effective date of this requirement. Assessments

1.16 must be conducted according to paragraphs (b) to (r).

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

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

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

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

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

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

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

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

2.32 (e) The certified assessor and the individual responsible for developing the coordinated
2.33 service and support plan must complete the community support plan and the coordinated
2.34 service and support plan no more than 60 calendar days from the assessment visit. The
2.35 person or the person's legal representative must be provided with a written community

3.1 support plan within the timelines established by the commissioner, regardless of whether
3.2 the person is eligible for Minnesota health care programs.

3.3 (f) For a person being assessed for ~~elderly waiver~~ customized living services under
3.4 chapter 256S or section 256B.49, a provider who submitted information under paragraph
3.5 (d) shall receive the final written community support plan when available and the Residential
3.6 Services Workbook or customized living tool.

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

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

3.9 (2) the individual's options and choices to meet identified needs, including:

3.10 (i) all available options for case management services and providers;

3.11 (ii) all available options for employment services, settings, and providers;

3.12 (iii) all available options for living arrangements;

3.13 (iv) all available options for self-directed services and supports, including self-directed
3.14 budget options; and

3.15 (v) service provided in a non-disability-specific setting;

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

3.18 (4) referral information; and

3.19 (5) informal caregiver supports, if applicable.

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

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

3.28 (i) The person has the right to make the final decision:

3.29 (1) between institutional placement and community placement after the recommendations
3.30 have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d);

4.1 (2) between community placement in a setting controlled by a provider and living
4.2 independently in a setting not controlled by a provider;

4.3 (3) between day services and employment services; and

4.4 (4) regarding available options for self-directed services and supports, including
4.5 self-directed funding options.

4.6 (j) The lead agency must give the person receiving long-term care consultation services
4.7 or the person's legal representative, materials, and forms supplied by the commissioner
4.8 containing the following information:

4.9 (1) written recommendations for community-based services and consumer-directed
4.10 options;

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

4.17 (3) the need for and purpose of preadmission screening conducted by long-term care
4.18 options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects
4.19 nursing facility placement. If the individual selects nursing facility placement, the lead
4.20 agency shall forward information needed to complete the level of care determinations and
4.21 screening for developmental disability and mental illness collected during the assessment
4.22 to the long-term care options counselor using forms provided by the commissioner;

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

4.27 (5) information about Minnesota health care programs;

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

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

4.31 (8) the certified assessor's decision regarding the person's need for institutional level of
4.32 care as determined under criteria established in subdivision 4e and the certified assessor's

5.1 decision regarding eligibility for all services and programs as defined in subdivision 1a,
5.2 paragraphs (a), clause (6), and (b);

5.3 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
5.4 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
5.5 (8), and (b), and incorporating the decision regarding the need for institutional level of care
5.6 or the lead agency's final decisions regarding public programs eligibility according to section
5.7 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right
5.8 to the person and must visually point out where in the document the right to appeal is stated;
5.9 and

5.10 (10) documentation that available options for employment services, independent living,
5.11 and self-directed services and supports were described to the individual.

5.12 (k) An assessment that is completed as part of an eligibility determination for multiple
5.13 programs for the alternative care, elderly waiver, developmental disabilities, community
5.14 access for disability inclusion, community alternative care, and brain injury waiver programs
5.15 under chapter 256S and sections 256B.0913, 256B.092, and 256B.49 is valid to establish
5.16 service eligibility for no more than 60 calendar days after the date of the assessment.

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

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

5.28 (n) If a person who receives home and community-based waiver services under section
5.29 256B.0913, 256B.092, or 256B.49 or chapter 256S temporarily enters for 121 days or fewer
5.30 a hospital, institution of mental disease, nursing facility, intensive residential treatment
5.31 services program, transitional care unit, or inpatient substance use disorder treatment setting,
5.32 the person may return to the community with home and community-based waiver services
5.33 under the same waiver, without requiring an assessment or reassessment under this section,
5.34 unless the person's annual reassessment is otherwise due. Nothing in this paragraph shall

6.1 change annual long-term care consultation reassessment requirements, payment for
6.2 institutional or treatment services, medical assistance financial eligibility, or any other law.

6.3 (o) At the time of reassessment, the certified assessor shall assess each person receiving
6.4 waiver residential supports and services currently residing in a community residential setting,
6.5 licensed adult foster care home that is either not the primary residence of the license holder
6.6 or in which the license holder is not the primary caregiver, family adult foster care residence,
6.7 customized living setting, or supervised living facility to determine if that person would
6.8 prefer to be served in a community-living setting as defined in section 256B.49, subdivision
6.9 23, in a setting not controlled by a provider, or to receive integrated community supports
6.10 as described in section 245D.03, subdivision 1, paragraph (c), clause (8). The certified
6.11 assessor shall offer the person, through a person-centered planning process, the option to
6.12 receive alternative housing and service options.

6.13 (p) At the time of reassessment, the certified assessor shall assess each person receiving
6.14 waiver day services to determine if that person would prefer to receive employment services
6.15 as described in section 245D.03, subdivision 1, paragraph (c), clauses (5) to (7). The certified
6.16 assessor shall describe to the person through a person-centered planning process the option
6.17 to receive employment services.

6.18 (q) At the time of reassessment, the certified assessor shall assess each person receiving
6.19 non-self-directed waiver services to determine if that person would prefer an available
6.20 service and setting option that would permit self-directed services and supports. The certified
6.21 assessor shall describe to the person through a person-centered planning process the option
6.22 to receive self-directed services and supports.

6.23 (r) All assessments performed according to this subdivision must be face-to-face unless
6.24 the assessment is a reassessment meeting the requirements of this paragraph. Remote
6.25 reassessments conducted by interactive video or telephone may substitute for face-to-face
6.26 reassessments. For services provided by the developmental disabilities waiver under section
6.27 256B.092, and the community access for disability inclusion, community alternative care,
6.28 and brain injury waiver programs under section 256B.49, remote reassessments may be
6.29 substituted for two consecutive reassessments if followed by a face-to-face reassessment.
6.30 For services provided by alternative care under section 256B.0913, essential community
6.31 supports under section 256B.0922, and the elderly waiver under chapter 256S, remote
6.32 reassessments may be substituted for one reassessment if followed by a face-to-face
6.33 reassessment. A remote reassessment is permitted only if the person being reassessed, or
6.34 the person's legal representative, and the lead agency case manager both agree that there is
6.35 no change in the person's condition, there is no need for a change in service, and that a

- 7.1 remote reassessment is appropriate. The person being reassessed, or the person's legal
7.2 representative, has the right to refuse a remote reassessment at any time. During a remote
7.3 reassessment, if the certified assessor determines a face-to-face reassessment is necessary
7.4 in order to complete the assessment, the lead agency shall schedule a face-to-face
7.5 reassessment. All other requirements of a face-to-face reassessment shall apply to a remote
7.6 reassessment, including updates to a person's support plan.