SENATE
STATE OF MINNESOTA
NINETY-SECOND SESSION

S.F. No. 2261

(SENATE AUTHORS: WIKLUND)

DATE	D-PG	OFFICIAL STATUS
03/22/2021	1120	Introduction and first reading Referred to Health and Human Services Finance and Policy See HF2128, Art. 3, Sec. 22-24, 43, 50 See First Special Session 2021, HF33, Art. 3, Sec. 47

A bill for an act

relating to health; changing certain health department provisions; amending Minnesota Statutes 2020, sections 62J.497, subdivisions 1, 3; 62J.63, subdivisions 1, 2; 144.0724, subdivisions 1, 2, 3a, 4, 5, 7, 8, 9, 12; 145.893, subdivision 1; 145.894; 145.897; 256.98, subdivision 1; Laws 2020, Seventh Special Session chapter 1, article 6, section 12, subdivision 4; repealing Minnesota Statutes 2020, sections 144.0721, subdivision 1; 144.0722; 144.693.

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

Section 1. Minnesota Statutes 2020, section 62J.497, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

(b) "Backward compatible" means that the newer version of a data transmission standard would retain, at a minimum, the full functionality of the versions previously adopted, and would permit the successful completion of the applicable transactions with entities that continue to use the older versions.

(c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(d) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription.

(e) "Electronic media" has the meaning given under Code of Federal Regulations, title 45, part 160.103.

(f) "E-prescribing" means the transmission using electronic media of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser and two-way transmissions related to eligibility, formulary, and medication history information.

(g) "Electronic prescription drug program" means a program that provides for e-prescribing.

(h) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

(i) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

(j) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, title 45, part 162.406.

(k) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

(l) "NCPDP Formulary and Benefits Standard" means the most recent version of the National Council for Prescription Drug Programs Formulary and Benefits Standard~~,~~ ~~Implementation Guide, Version 1, Release 0, October 2005~~ or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance.

(m) "NCPDP SCRIPT Standard" means the most recent version of the National Council for Prescription Drug Programs ~~Prescriber/Pharmacist Interface~~ SCRIPT Standard, ~~Implementation Guide Version 8, Release 1 (Version 8.1), October 2005,~~ or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance. ~~Subsequently released versions of the NCPDP SCRIPT Standard may be used, provided that the new version of the standard is backward compatible to the current version adopted by the Centers for Medicare and Medicaid Services.~~

(n) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

(o) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as defined in section 151.01, subdivision 23.

(p) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.

(q) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

Sec. 2. Minnesota Statutes 2020, section 62J.497, subdivision 3, is amended to read:

Subd. 3. **Standards for electronic prescribing.** (a) Prescribers and dispensers must use the NCPDP SCRIPT Standard for the communication of a prescription or prescription-related information. ~~The NCPDP SCRIPT Standard shall be used to conduct the following transactions:~~

~~(1) get message transaction;~~

~~(2) status response transaction;~~

~~(3) error response transaction;~~

~~(4) new prescription transaction;~~

~~(5) prescription change request transaction;~~

~~(6) prescription change response transaction;~~

~~(7) refill prescription request transaction;~~

~~(8) refill prescription response transaction;~~

~~(9) verification transaction;~~

~~(10) password change transaction;~~

~~(11) cancel prescription request transaction; and~~

~~(12) cancel prescription response transaction.~~

(b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP SCRIPT Standard for communicating and transmitting medication history information.

(c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP Formulary and Benefits Standard for communicating and transmitting formulary and benefit information.

(d) Providers, group purchasers, prescribers, and dispensers must use the national provider identifier to identify a health care provider in e-prescribing or prescription-related transactions when a health care provider's identifier is required.

(e) Providers, group purchasers, prescribers, and dispensers must communicate eligibility information and conduct health care eligibility benefit inquiry and response transactions according to the requirements of section 62J.536.

Sec. 3. Minnesota Statutes 2020, section 62J.63, subdivision 1, is amended to read:

Subdivision 1. **Establishment; administration.** The commissioner of health shall ~~establish and administer the Center for Health Care Purchasing Improvement as an administrative unit within the Department of Health. The Center for Health Care Purchasing Improvement shall~~ support the state in its efforts to be a more prudent and efficient purchaser of quality health care services~~. The center shall~~, aid the state in developing and using more common strategies and approaches for health care performance measurement and health care purchasing~~. The common strategies and approaches shall~~, promote greater transparency of health care costs and quality~~,~~ and greater accountability for health care results and improvement~~. The center shall also~~, and identify barriers to more efficient, effective, quality health care and options for overcoming the barriers.

Sec. 4. Minnesota Statutes 2020, section 62J.63, subdivision 2, is amended to read:

Subd. 2. **Staffing; duties; scope.** ~~(a)~~ The commissioner of health may ~~appoint a director, and up to three additional senior-level staff or codirectors, and other staff as needed who are under the direction of the commissioner. The staff of the center are in the unclassified service.~~:

~~(b) With the authorization of the commissioner of health, and in consultation or interagency agreement with the appropriate commissioners of state agencies, the director, or codirectors, may:~~

~~(1) initiate projects to develop plan designs for state health care purchasing;~~

~~(2)~~ (1) require reports or surveys to evaluate the performance of current health care purchasing or administrative simplication strategies;

~~(3)~~ (2) calculate fiscal impacts, including net savings and return on investment, of health care purchasing strategies and initiatives;

~~(4) conduct policy audits of state programs to measure conformity to state statute or other purchasing initiatives or objectives;~~

~~(5)~~ (3) support the Administrative Uniformity Committee under ~~section~~ sections 62J.50 and 62J.536 and other relevant groups or activities to advance agreement on health care administrative process streamlining;

~~(6) consult with the Health Economics Unit of the Department of Health regarding reports and assessments of the health care marketplace;~~

~~(7) consult with the Department of Commerce regarding health care regulatory issues and legislative initiatives;~~

~~(8) work with appropriate Department of Human Services staff and the Centers for Medicare and Medicaid Services to address federal requirements and conformity issues for health care purchasing;~~

~~(9) assist the Minnesota Comprehensive Health Association in health care purchasing strategies;~~

~~(10) convene medical directors of agencies engaged in health care purchasing for advice, collaboration, and exploring possible synergies;~~

~~(11)~~ (4) contact and participate with other relevant health care task forces, study activities, and similar efforts with regard to health care performance measurement and performance-based purchasing; and

~~(12)~~ (5) assist in seeking external funding through appropriate grants or other funding opportunities and may administer grants and externally funded projects.

Sec. 5. Minnesota Statutes 2020, section 144.0724, subdivision 1, is amended to read:

Subdivision 1. **Resident reimbursement case mix classifications.** The commissioner of health shall establish resident reimbursement case mix classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under this section and according to section 256R.17.

Sec. 6. Minnesota Statutes 2020, section 144.0724, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given.

(a) "Assessment reference date" or "ARD" means the specific end point for look-back periods in the MDS assessment process. This look-back period is also called the observation or assessment period.

(b) "Case mix index" means the weighting factors assigned to the RUG-IV classifications.

(c) "Index maximization" means classifying a resident who could be assigned to more than one category, to the category with the highest case mix index.

(d) "Minimum Data Set" or "MDS" means a core set of screening, clinical assessment, and functional status elements, that include common definitions and coding categories specified by the Centers for Medicare and Medicaid Services and designated by the ~~Minnesota~~ Department of Health.

(e) "Representative" means a person who is the resident's guardian or conservator, the person authorized to pay the nursing home expenses of the resident, a representative of the Office of Ombudsman for Long-Term Care whose assistance has been requested, or any other individual designated by the resident.

(f) "Resource utilization groups" or "RUG" means the system for grouping a nursing facility's residents according to their clinical and functional status identified in data supplied by the facility's Minimum Data Set.

(g) "Activities of daily living" ~~means grooming,~~includes: personal hygiene, dressing, bathing, transferring, bed mobility, ~~positioning,~~ locomotion, eating, and toileting.

(h) "Nursing facility level of care determination" means the assessment process that results in a determination of a resident's or prospective resident's need for nursing facility level of care as established in subdivision 11 for purposes of medical assistance payment of long-term care services for:

(1) nursing facility services under section 256B.434 or chapter 256R;

(2) elderly waiver services under chapter 256S;

(3) CADI and BI waiver services under section 256B.49; and

(4) state payment of alternative care services under section 256B.0913.

Sec. 7. Minnesota Statutes 2020, section 144.0724, subdivision 3a, is amended to read:

Subd. 3a. **Resident reimbursement case mix classifications beginning January 1, 2012.** (a) Beginning January 1, 2012, resident reimbursement case mix classifications shall be based on the Minimum Data Set, version 3.0 assessment instrument, or its successor version mandated by the Centers for Medicare and Medicaid Services that nursing facilities are required to complete for all residents. The commissioner of health shall establish resident classifications according to the RUG-IV, 48 group, resource utilization groups. Resident classification must be established based on the individual items on the Minimum Data Set, which must be completed according to the Long Term Care Facility Resident Assessment

Instrument User's Manual Version 3.0 or its successor issued by the Centers for Medicare and Medicaid Services.

(b) Each resident must be classified based on the information from the Minimum Data Set according to general categories ~~as defined in the Case Mix Classification Manual for Nursing Facilities~~ issued by the Minnesota Department of Health.

Sec. 8. Minnesota Statutes 2020, section 144.0724, subdivision 4, is amended to read:

Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit to the ~~commissioner of health~~ federal data base MDS assessments that conform with the assessment schedule defined by ~~Code of Federal Regulations, title 42, section 483.20, and published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, in the Long-Term Care Assessment Instrument User's Manual, version 3.0, and subsequent updates when issued by the Centers for Medicare and Medicaid Services~~ Long-Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 or its successor issued by the Centers for Medicare and Medicaid Services. The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, to replace or supplement the current version of the manual or document.

(b) The OBRA assessments used to determine a case mix classification for reimbursement include the following:

(1) ~~a new~~ an admission assessment;

(2) an annual assessment ~~which must have an assessment reference date (ARD) within 92 days of the previous assessment and the previous comprehensive assessment~~;

(3) a significant change in status assessment ~~must be completed within 14 days of the identification of a significant change, whether improvement or decline, and regardless of the amount of time since the last significant change in status assessment~~;

(4) all quarterly assessments ~~must have an assessment reference date (ARD) within 92 days of the ARD of the previous assessment~~;

(5) ~~any~~ significant correction to a prior comprehensive assessment, if the corrected assessment ~~being corrected~~ is the current ~~one~~ assessment being used for ~~RUG classification~~ payment; ~~and~~

(6) ~~any~~ significant correction to a prior quarterly assessment, if the corrected assessment ~~being corrected~~ is the current ~~one~~ assessment being used for ~~RUG classification.~~ payment; and

(7) modifications to the most recent assessments in clauses (1) to (6).

(c) In addition to the assessments listed in paragraph (b), the assessments used to determine nursing facility level of care include the following:

(1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by the Senior LinkAge Line or other organization under contract with the Minnesota Board on Aging; and

(2) a nursing facility level of care determination as provided for under section 256B.0911, subdivision 4e, as part of a face-to-face long-term care consultation assessment completed under section 256B.0911, by a county, tribe, or managed care organization under contract with the Department of Human Services.

Sec. 9. Minnesota Statutes 2020, section 144.0724, subdivision 5, is amended to read:

Subd. 5. **Short stays.** (a) A facility must submit to the commissioner of health an admission assessment for all residents who stay in the facility 14 days or less~~.~~, unless the resident is admitted and discharged from the facility on the same day, in which case the admission assessment is not required. When an admission assessment is not submitted, the case mix classification will be the rate with a case mix index of 1.0.

(b) Notwithstanding the admission assessment requirements of paragraph (a), a facility may elect to accept a short stay rate with a case mix index of 1.0 for all facility residents who stay 14 days or less in lieu of submitting an admission assessment. Facilities shall make this election annually.

(c) Nursing facilities must elect one of the options described in paragraphs (a) and (b) by reporting to the commissioner of health, as prescribed by the commissioner. The election is effective on July 1 each year.

Sec. 10. Minnesota Statutes 2020, section 144.0724, subdivision 7, is amended to read:

Subd. 7. **Notice of resident reimbursement case mix classification.** (a) The commissioner of health shall provide to a nursing facility a notice for each resident of the ~~reimbursement~~ classification established under subdivision 1. The notice must inform the resident of the case mix classification ~~that was~~ assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the

commissioner, and the opportunity to request a reconsideration of the classification and the address and telephone number of the Office of Ombudsman for Long-Term Care. The commissioner must transmit the notice of resident classification by electronic means to the nursing facility. ~~A~~ The nursing facility is responsible for the distribution of the notice to each resident~~, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident~~ or the resident's representative. This notice must be distributed within three ~~working~~ business days after the facility's receipt ~~of the electronic file of notice of case mix classifications from the commissioner of health~~.

(b) If a facility submits a ~~modification to the most recent assessment used to establish a case mix classification conducted under subdivision 3 that results~~ modifying assessment resulting in a change ~~in~~ of the case mix classification, the facility ~~shall give~~ must provide a written notice to the resident or the resident's representative ~~about~~ regarding the item or items that ~~was~~ were modified and the reason for the ~~modification~~ modifications. The notice ~~of modified assessment may~~ must be provided ~~at the same time that the resident or resident's representative is provided the resident's modified notice of classification~~ within three business days of the resident classification notice.

Sec. 11. Minnesota Statutes 2020, section 144.0724, subdivision 8, is amended to read:

Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, or resident's representative, or the nursing facility, or ~~boarding~~ board and care home may request that the commissioner of health reconsider the assigned reimbursement case mix classification and any item or items changed during the audit process. The request for reconsideration must be submitted in writing to the commissioner ~~within 30 days of the day the resident or the resident's representative receives the resident classification notice~~ of health.

(b) For reconsideration requests initiated by the resident or the resident's representative:

(1) The resident or the resident's representative must submit in writing a reconsideration request to the facility administrator within 30 days of receipt of the resident classification notice. The written request ~~for reconsideration~~ must include the ~~name of the resident, the name and address of the facility in which the resident resides, the~~ reasons for the reconsideration~~, and documentation supporting the~~ request. ~~The documentation accompanying the reconsideration request is limited to a copy of the MDS that determined the classification and other documents that would support or change the MDS findings.~~

(2) Within three business days of receiving the reconsideration request, the nursing facility must submit to the commissioner of health a completed reconsideration request

form, a copy of the resident's or resident's representative's written request, and all supporting documentation used to complete the assessment being considered. If the facility fails to provide the required information, the reconsideration will be completed with the information submitted and the facility cannot make further reconsideration requests on this classification.

~~(b)~~ (3) Upon written request and within three business days, the nursing facility must give the resident or the resident's representative a copy of the assessment ~~form~~ being reconsidered and ~~the other~~ all supporting documentation ~~that was given to the commissioner of health~~ used to ~~support~~ complete the assessment ~~findings~~. ~~The nursing facility shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information.~~ Notwithstanding any law to the contrary, the facility may not charge a fee for providing copies of the requested documentation. If a facility fails to provide the ~~material~~ required documents within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the nursing facility immediately comply with the request for information and that as of the date of the issuance of the correction order, the facility shall forfeit to the state a $100 fine for the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues.

(c) ~~in addition to the information required under paragraphs (a) and (b), a reconsideration request from a nursing facility must contain the following information: (i) the date the reimbursement classification notices were received by the facility; (ii) the date the classification notices were distributed to the resident or the resident's representative; and (iii)~~ For reconsideration requests initiated by the facility:

(1) The facility is required to inform the resident or the resident's representative in writing that a reconsideration of the resident's case mix classification is being requested. The notice must inform the resident or the resident's representative:

(i) of the date and reason for the reconsideration request;

(ii) of the potential for a classification and subsequent rate change;

(iii) of the extent of the potential rate change;

(iv) that copies of the request and supporting documentation are available for review; and

(v) that the resident or the resident's representative has the right to request a reconsideration.

(2) Within 30 days of receipt of the audit exit report or resident classification notice, the facility must submit to the commissioner of health a completed reconsideration request form, all supporting documentation used to complete the assessment being reconsidered, and a copy of ~~a~~ the notice ~~sent to~~ informing the resident or ~~to~~ the resident's representative~~.~~ ~~This notice must inform the resident or the resident's representative~~ that a reconsideration of the resident's classification is being requested~~, the reason for the request, that the resident's rate will change if the request is approved by the commissioner, the extent of the change, that copies of the facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration~~.

(3) If the facility fails to provide the required information ~~listed in item (iii) with the reconsideration request, the commissioner may request that the facility provide the information within 14 calendar days.~~, the reconsideration request ~~must~~ may be denied ~~if the information is then not provided,~~ and the facility may not make further reconsideration requests on ~~that specific reimbursement~~ this classification.

(d) Reconsideration by the commissioner must be made by individuals not involved in reviewing the assessment, audit, or reconsideration that established the disputed classification. The reconsideration must be based upon the assessment that determined the classification and upon the information provided to the commissioner of health under paragraphs (a) ~~and (b)~~ to (c). If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. Within 15 ~~working~~ business days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect characteristics of the resident at the time of the assessment. ~~The resident and the nursing facility or boarding care home shall be notified within five working days after the decision is made.~~ The commissioner must transmit the reconsideration classification notice by electronic means to the nursing facility. The nursing facility is responsible for the distribution of the notice to the resident or the resident's representative. The notice must be distributed by the nursing facility within three business days after receipt. A decision by the commissioner under this subdivision is the final administrative decision of the agency for the party requesting reconsideration.

(e) The ~~resident~~ case mix classification established by the commissioner shall be the classification ~~that~~ which applies to the resident while the request for reconsideration is pending. If a request for reconsideration applies to an assessment used to determine nursing

facility level of care under subdivision 4, paragraph (c), the resident shall continue to be eligible for nursing facility level of care while the request for reconsideration is pending.

(f) The commissioner may request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

Sec. 12. Minnesota Statutes 2020, section 144.0724, subdivision 9, is amended to read:

Subd. 9. **Audit authority.** (a) The commissioner shall audit the accuracy of resident assessments performed under section 256R.17 through any of the following: desk audits; on-site review of residents and their records; and interviews with staff, residents, or residents' families. The commissioner shall reclassify a resident if the commissioner determines that the resident was incorrectly classified.

(b) The commissioner is authorized to conduct on-site audits on an unannounced basis.

(c) A facility must grant the commissioner access to examine the medical records relating to the resident assessments selected for audit under this subdivision. The commissioner may also observe and speak to facility staff and residents.

(d) The commissioner shall consider documentation under the time frames for coding items on the minimum data set as set out in the Long-Term Care Facility Resident Assessment Instrument User's Manual published by the Centers for Medicare and Medicaid Services.

(e) The commissioner shall develop an audit selection procedure that includes the following factors:

(1) Each facility shall be audited annually. If a facility has two successive audits in which the percentage of change is five percent or less and the facility has not been the subject of a special audit in the past 36 months, the facility may be audited biannually. A stratified sample of 15 percent, with a minimum of ten assessments, of the most current assessments shall be selected for audit. If more than 20 percent of the RUG-IV classifications are changed as a result of the audit, the audit shall be expanded to a second 15 percent sample, with a minimum of ten assessments. If the total change between the first and second samples is 35 percent or greater, the commissioner may expand the audit to all of the remaining assessments.

(2) If a facility qualifies for an expanded audit, the commissioner may audit the facility again within six months. If a facility has two expanded audits within a 24-month period, that facility will be audited at least every six months for the next 18 months.

(3) The commissioner may conduct special audits if the commissioner determines that circumstances exist that could alter or affect the validity of case mix classifications of residents. These circumstances include, but are not limited to, the following:

(i) frequent changes in the administration or management of the facility;

(ii) an unusually high percentage of residents in a specific case mix classification;

(iii) a high frequency in the number of reconsideration requests received from a facility;

(iv) frequent adjustments of case mix classifications as the result of reconsiderations or audits;

(v) a criminal indictment alleging provider fraud;

(vi) other similar factors that relate to a facility's ability to conduct accurate assessments;

(vii) an atypical pattern of scoring minimum data set items;

(viii) nonsubmission of assessments;

(ix) late submission of assessments; or

(x) a previous history of audit changes of 35 percent or greater.

(f) ~~Within 15 working days of completing the audit process, the commissioner shall make available electronically the results of the audit to the facility. If the results of the audit reflect a change in the resident's case mix classification, a case mix classification notice will be made available electronically to the facility, using the procedure in subdivision 7, paragraph (a). The notice must contain the resident's classification and a statement informing the resident, the resident's authorized representative, and the facility of their right to review the commissioner's documents supporting the classification and to request a reconsideration of the classification. This notice must also include the address and telephone number of the Office of Ombudsman for Long-Term Care.~~ If the audit results in a case mix classification change, the commissioner must transmit the audit classification notice by electronic means to the nursing facility within 15 business days of completing an audit. The nursing facility is responsible for distribution of the notice to each resident or the resident's representative. This notice must be distributed by the nursing facility within three business days after receipt. The notice must inform the resident of the case mix classification assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, the opportunity to request a reconsideration of the classification, and the address and telephone number of the Office of Ombudsman for Long-Term Care.

Sec. 13. Minnesota Statutes 2020, section 144.0724, subdivision 12, is amended to read:

Subd. 12. **Appeal of nursing facility level of care determination.** (a) 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 (9).

(b) The commissioner of human services shall ensure that notice of changes in eligibility due to a nursing facility level of care determination is provided to each affected recipient or the recipient's guardian at least 30 days before the effective date of the change. The notice shall include the following information:

(1) how to obtain further information on the changes;

(2) how to receive assistance in obtaining other services;

(3) a list of community resources; and

(4) appeal rights.

~~A recipient who meets the criteria in section 256B.0922, subdivision 2, paragraph (a), clauses (1) and (2), may request continued services pending appeal within the time period allowed to request an appeal under section 256.045, subdivision 3, paragraph (i). This paragraph is in effect for appeals filed between January 1, 2015, and December 31, 2016.~~

Sec. 14. Minnesota Statutes 2020, section 145.893, subdivision 1, is amended to read:

Subdivision 1. ~~**Vouchers**~~ **Food benefits.** An eligible individual shall receive ~~vouchers~~ food benefits for the purchase of specified nutritional supplements in type and quantity approved by the commissioner. Alternate forms of delivery may be developed by the commissioner in appropriate cases.

Sec. 15. Minnesota Statutes 2020, section 145.894, is amended to read:

145.894 STATE COMMISSIONER OF HEALTH; DUTIES, RESPONSIBILITIES.

The commissioner of health shall:

(1) develop a comprehensive state plan for the delivery of nutritional supplements to pregnant and lactating women, infants, and children;

(2) contract with existing local public or private nonprofit organizations for the administration of the nutritional supplement program;

(3) develop and implement a public education program promoting the provisions of sections 145.891 to 145.897, and provide for the delivery of individual and family nutrition education and counseling at project sites. The education programs must include a campaign to promote breast feeding;

(4) develop in cooperation with other agencies and vendors a uniform state voucher system for the delivery of nutritional supplements;

(5) authorize local health agencies to issue ~~vouchers bimonthly~~ food benefits trimonthly to some or all eligible individuals served by the agency, provided the agency demonstrates that the federal minimum requirements for providing nutrition education will continue to be met and that the quality of nutrition education and health services provided by the agency will not be adversely impacted;

(6) investigate and implement a system to reduce the cost of nutritional supplements and maintain ongoing negotiations with nonparticipating manufacturers and suppliers to maximize cost savings;

(7) develop, analyze, and evaluate the health aspects of the nutritional supplement program and establish nutritional guidelines for the program;

(8) apply for, administer, and annually expend at least 99 percent of available federal or private funds;

(9) aggressively market services to eligible individuals by conducting ongoing outreach activities and by coordinating with and providing marketing materials and technical assistance to local human services and community service agencies and nonprofit service providers;

(10) determine, on July 1 of each year, the number of pregnant women participating in each special supplemental food program for women, infants, and children (WIC) and, ~~in 1986, 1987, and 1988,~~ at the commissioner's discretion, designate a different food program deliverer if the current deliverer fails to increase the participation of pregnant women in the program by at least ten percent over the previous year's participation rate;

(11) promulgate all rules necessary to carry out the provisions of sections 145.891 to 145.897; and

(12) ensure that any state appropriation to supplement the federal program is spent consistent with federal requirements.

Sec. 16. Minnesota Statutes 2020, section 145.897, is amended to read:

145.897 ~~VOUCHERS~~ FOOD BENEFITS.

~~Vouchers~~ Food benefits issued pursuant to sections 145.891 to 145.897 shall be only for the purchase of those foods determined by the ~~commissioner~~ United States Department of Agriculture to be desirable nutritional supplements for pregnant and lactating women, infants and children. ~~These foods shall include, but not be limited to, iron fortified infant formula, vegetable or fruit juices, cereal, milk, cheese, and eggs.~~

Sec. 17. Minnesota Statutes 2020, section 256.98, subdivision 1, is amended to read:

Subdivision 1. **Wrongfully obtaining assistance.** (a) A person who commits any of the following acts or omissions with intent to defeat the purposes of sections 145.891 to 145.897, the MFIP program formerly codified in sections 256.031 to 256.0361, the AFDC program formerly codified in sections 256.72 to 256.871, chapter 256B, 256D, 256I, 256J, 256K, or 256L, child care assistance programs, and emergency assistance programs under section 256D.06, is guilty of theft and shall be sentenced under section 609.52, subdivision 3, clauses (1) to (5):

(1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, by intentional concealment of any material fact, or by impersonation or other fraudulent device, assistance or the continued receipt of assistance, to include child care assistance or ~~vouchers~~ food benefits produced according to sections 145.891 to 145.897 and MinnesotaCare services according to sections 256.9365, 256.94, and 256L.01 to 256L.15, to which the person is not entitled or assistance greater than that to which the person is entitled;

(2) knowingly aids or abets in buying or in any way disposing of the property of a recipient or applicant of assistance without the consent of the county agency; or

(3) obtains or attempts to obtain, alone or in collusion with others, the receipt of payments to which the individual is not entitled as a provider of subsidized child care, or by furnishing or concurring in a willfully false claim for child care assistance.

(b) The continued receipt of assistance to which the person is not entitled or greater than that to which the person is entitled as a result of any of the acts, failure to act, or concealment described in this subdivision shall be deemed to be continuing offenses from the date that the first act or failure to act occurred.

Sec. 18. Laws 2020, Seventh Special Session chapter 1, article 6, section 12, subdivision 4, is amended to read:

Subd. 4. **Housing with services establishment registration; conversion to an assisted living facility license.** (a) Housing with services establishments registered under chapter 144D, providing home care services according to chapter 144A to at least one resident, and intending to provide assisted living services on or after August 1, 2021, must submit an application for an assisted living facility license in accordance with section 144G.12 no later than June 1, 2021. The commissioner shall consider the application in accordance with section ~~144G.16~~ 144G.15.

(b) Notwithstanding the housing with services contract requirements identified in section 144D.04, any existing housing with services establishment registered under chapter 144D that does not intend to convert its registration to an assisted living facility license under this chapter must provide written notice to its residents at least 60 days before the expiration of its registration, or no later than May 31, 2021, whichever is earlier. The notice must:

(1) state that the housing with services establishment does not intend to convert to an assisted living facility;

(2) include the date when the housing with services establishment will no longer provide housing with services;

(3) include the name, e-mail address, and phone number of the individual associated with the housing with services establishment that the recipient of home care services may contact to discuss the notice;

(4) include the contact information consisting of the phone number, e-mail address, mailing address, and website for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; and

(5) for residents who receive home and community-based waiver services under section 256B.49 and chapter 256S, also be provided to the resident's case manager at the same time that it is provided to the resident.

(c) A housing with services registrant that obtains an assisted living facility license, but does so under a different business name as a result of reincorporation, and continues to provide services to the recipient, is not subject to the 60-day notice required under paragraph (b). However, the provider must otherwise provide notice to the recipient as required under sections 144D.04 and 144D.045, as applicable, and section 144D.09.

(d) All registered housing with services establishments providing assisted living under sections 144G.01 to 144G.07 prior to August 1, 2021, must have an assisted living facility license under this chapter.

(e) Effective August 1, 2021, any housing with services establishment registered under chapter 144D that has not converted its registration to an assisted living facility license under this chapter is prohibited from providing assisted living services.

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

Sec. 19. **REPEALER.**

Minnesota Statutes 2020, sections 144.0721, subdivision 1; 144.0722; and 144.693, are repealed.

144.0721 ASSESSMENTS OF CARE AND SERVICES TO NURSING HOME RESIDENTS.

Subdivision 1. **Appropriateness and quality.** Until the date of implementation of the revised case mix system based on the minimum data set, the commissioner of health shall assess the appropriateness and quality of care and services furnished to private paying residents in nursing homes and boarding care homes that are certified for participation in the medical assistance program under United States Code, title 42, sections 1396-1396p. These assessments shall be conducted until the date of implementation of the revised case mix system with the exception of provisions requiring recommendations for changes in the level of care provided to the private paying residents.

144.0722 RESIDENT REIMBURSEMENT CLASSIFICATIONS.

Subdivision 1. **Resident reimbursement classifications.** The commissioner of health shall establish resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under section 144.0721, or under rules established by the commissioner of human services under chapter 256R. The reimbursement classifications established by the commissioner must conform to the rules established by the commissioner of human services.

Subd. 2. **Notice of resident reimbursement classification.** The commissioner of health shall notify each resident, and the nursing home or boarding care home in which the resident resides, of the reimbursement classification established under subdivision 1. The notice must inform the resident of the classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, and the opportunity to request a reconsideration of the classification. The notice of resident classification must be sent by first-class mail. The individual resident notices may be sent to the resident's nursing home or boarding care home for distribution to the resident. The nursing home or boarding care home is responsible for the distribution of the notice to each resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident. This notice must be distributed within three working days after the facility's receipt of the notices from the department.

Subd. 2a. **Semiannual assessment by nursing facilities.** Notwithstanding Minnesota Rules, part 9549.0059, subpart 2, item B, the individual dependencies items 21 to 24 and 28 are required to be completed in accordance with the Facility Manual for Completing Case Mix Requests for Classification, July 1987, issued by the Minnesota Department of Health.

Subd. 3. **Request for reconsideration.** The resident or the nursing home or boarding care home may request that the commissioner reconsider the assigned reimbursement classification. The request for reconsideration must be submitted in writing to the commissioner within 30 days of the receipt of the notice of resident classification. For reconsideration requests submitted by or on behalf of the resident, the time period for submission of the request begins as of the date the resident or the resident's representative receives the classification notice. The request for reconsideration must include the name of the resident, the name and address of the facility in which the resident resides, the reasons for the reconsideration, the requested classification changes, and documentation supporting the requested classification. The documentation accompanying the reconsideration request is limited to documentation establishing that the needs of the resident at the time of the assessment resulting in the disputed classification justify a change of classification.

Subd. 3a. **Access to information.** Upon written request, the nursing home or boarding care home must give the resident or the resident's representative a copy of the assessment form and the other documentation that was given to the department to support the assessment findings. The nursing home or boarding care home shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information. If a facility fails to provide the material within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the facility immediately comply with the request for information and that as of the date of the issuance of the correction order, the facility shall forfeit to the state a $100 fine the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues. For the purposes of this section, "representative" includes the resident's guardian or conservator, the person authorized to pay the nursing home expenses of the resident, a representative of the nursing home ombudsman's office whose assistance has been requested, or any other individual designated by the resident.

Subd. 3b. **Facility's request for reconsideration.** In addition to the information required in subdivision 3, a reconsideration request from a nursing home or boarding care home must contain the following information: the date the resident reimbursement classification notices were received by the facility; the date the classification notices were distributed to the resident or the resident's representative; and a copy of a notice sent to the resident or to the resident's representative. This notice must tell the resident or the resident's representative that a reconsideration of the resident's classification is being requested, the reason for the request, that the resident's rate will change if the request is approved by the department and the extent of the change, that copies of the facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration. If the facility fails to provide this information with the reconsideration request, the request must be denied, and the facility may not make further reconsideration requests on that specific reimbursement classification.

Subd. 4. **Reconsideration.** The commissioner's reconsideration must be made by individuals not involved in reviewing the assessment that established the disputed classification. The reconsideration must be based upon the initial assessment and upon the information provided to the commissioner under subdivision 3. If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. In its discretion, the commissioner may review the reimbursement classifications assigned to all residents in the facility. Within 15 working days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect the needs of the resident at the time of the assessment. The resident and the nursing home or boarding care home shall be notified within five working days after the decision is made. The commissioner's decision under this subdivision is the final administrative decision of the agency.

Subd. 5. **Audit authority.** The Department of Health may audit assessments of nursing home and boarding care home residents. These audits may be in addition to the assessments completed by the department under section 144.0721. The audits may be conducted at the facility, and the department may conduct the audits on an unannounced basis.

144.693 MEDICAL MALPRACTICE CLAIMS; REPORTS.

Subdivision 1. **Insurers' reports to commissioner.** On or before September 1, 1976, and on or before March 1 and September 1 of each year thereafter, each insurer providing professional liability insurance to one or more hospitals, outpatient surgery centers, or health maintenance organizations, shall submit to the state commissioner of health a report listing by facility or organization all claims which have been closed by or filed with the insurer during the period ending December 31 of the previous year or June 30 of the current year. The report shall contain, but not be limited to, the following information:

(1) the total number of claims made against each facility or organization which were filed or closed during the reporting period;

(2) the date each new claim was filed with the insurer;

(3) the allegations contained in each claim filed during the reporting period;

(4) the disposition and closing date of each claim closed during the reporting period;

(5) the dollar amount of the award or settlement for each claim closed during the reporting period; and

(6) any other information the commissioner of health may, by rule, require.

Any hospital, outpatient surgery center, or health maintenance organization which is self insured shall be considered to be an insurer for the purposes of this section and shall comply with the reporting provisions of this section.

A report from an insurer submitted pursuant to this section is private data, as defined in section 13.02, subdivision 12, accessible to the facility or organization which is the subject of the data, and to its authorized agents. Any data relating to patient records which is reported to the state commissioner of health pursuant to this section shall be reported in the form of summary data, as defined in section 13.02, subdivision 19.

Subd. 2. **Report to legislature.** The state commissioner of health shall collect and review the data reported pursuant to subdivision 1. On December 1, 1976, and on January 2 of each year thereafter, the state commissioner of health shall report to the legislature the findings related to the incidence and size of malpractice claims against hospitals, outpatient surgery centers, and health

maintenance organizations, and shall make any appropriate recommendations to reduce the incidence and size of the claims. Data published by the state commissioner of health pursuant to this subdivision with respect to malpractice claims information shall be summary data within the meaning of section 13.02, subdivision 19.

Subd. 3. **Access to insurers' records.** The state commissioner of health shall have access to the records of any insurer relating to malpractice claims made against hospitals, outpatient surgery centers, and health maintenance organizations in years prior to 1976 if the commissioner determines the records are necessary to fulfill the duties of the commissioner under Laws 1976, chapter 325.