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State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-EIGHTH SESSION

H. F. No. 767

02/21/2013 Authored by Morgan and Schoen

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

1.1 A bill for an act
1.2 relating to human services; making changes to continuing care provisions;
1.3 modifying provisions related to advisory task forces, nursing homes, resident
1.4 relocation, medical assistance, long-term care consultation services, assessments,
1.5 and reporting of maltreatment; amending Minnesota Statutes 2012, sections
1.6 15.014, subdivision 2; 144A.071, subdivision 4d; 144A.161; 256B.057,
1.7 subdivision 9; 256B.0652, subdivision 5; 256B.0911, subdivisions 2b, 3, 3a, 6;
1.8 256B.092, subdivision 7; 256B.441, subdivisions 1, 43, 63; 256B.49, subdivision
1.9 14; 256B.492; 626.557, subdivision 10; repealing Minnesota Statutes 2012,
1.10 section 256B.437, subdivision 8; Laws 2012, chapter 216, article 11, section 31.

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

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

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

2.1 Sec. 2. Minnesota Statutes 2012, section 144A.071, subdivision 4d, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

3.4 (7) the savings from not paying property payment rate adjustments from submission
3.5 of renovation costs that would otherwise be eligible as threshold projects under section
3.6 256B.434, subdivision 4f.

3.7 (c) For purposes of the calculation in paragraph (a), clause (3), the estimated medical
3.8 assistance resident days of the remaining facility or facilities shall be computed assuming
3.9 95 percent occupancy multiplied by the historical percentage of medical assistance
3.10 resident days of the remaining facility or facilities, as reported on the facility's or facilities'
3.11 most recent nursing facility statistical and cost report filed before the plan of closure
3.12 is submitted, multiplied by 365.

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

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

3.20 (1) submit an application for closure according to section 256B.437, subdivision
3.21 3; and

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

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

3.28 Sec. 3. Minnesota Statutes 2012, section 144A.161, is amended to read:

3.29 **144A.161 NURSING HOME AND BOARDING CARE HOME RESIDENT**
3.30 **RELOCATION.**

3.31 Subdivision 1. **Definitions.** The definitions in this subdivision apply to subdivisions
3.32 2 to 10.

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

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

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

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

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

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

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

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

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

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

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

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

4.29 Subd. 1a. **Scope.** Where a facility is undertaking a closure, ~~curtailment,~~ reduction,
 4.30 or change in operations, or where a housing with services unit registered under chapter
 4.31 144D is closed because the space that it occupies is being replaced by a nursing facility
 4.32 bed that is being reactivated from layaway status, the facility and the county social
 4.33 services agency must comply with the requirements of this section.

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

5.1 (1) the commissioner of health;
 5.2 (2) the commissioner of human services;
 5.3 (3) the county social services agency;
 5.4 (4) the Office of Ombudsman for Long-Term Care; ~~and~~
 5.5 (5) the Office of Ombudsman for Mental Health and Developmental Disabilities; and
 5.6 (6) the managed care organizations contracting with Minnesota health care programs
 5.7 within the county where the nursing facility is located.

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

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

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

5.21 Subd. 3. **Planning process.** (a) The county social services agency shall, within
 5.22 five working days of receiving initial notice of the licensee's intent to close ~~or curtail~~,
 5.23 reduce, or change operations, provide the licensee and all parties identified in subdivision
 5.24 2, paragraph (a), with the ~~names, telephone numbers, facsimile numbers, and e-mail~~
 5.25 ~~addresses~~ contact information of those persons responsible for coordinating county social
 5.26 services agency efforts in the planning process.

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

6.1 ~~process under this subdivision to occur concurrent with the 60-day notice required under~~
 6.2 ~~subdivision 5a.~~ The plan shall:

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

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

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

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

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

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

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

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

6.18 ~~(9)~~ (8) identify a schedule for the timely completion of each element of the plan; ~~and~~

6.19 ~~(10)~~ (9) identify the steps the licensee and the county social services agency will
 6.20 take to address the relocation needs of individual residents who may be difficult to place
 6.21 due to specialized care needs such as behavioral health problems; and

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

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

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

6.34 Subd. 5. **Licensee responsibilities prior related to relocation sending the notice**
 6.35 **in subdivision 5a.** (a) The licensee shall establish an interdisciplinary team responsible
 6.36 for coordinating and implementing the plan. The interdisciplinary team shall include

7.1 representatives from the county social services agency, the Office of Ombudsman for
 7.2 Long-Term Care, the Office of the Ombudsman for Mental Health and Developmental
 7.3 Disabilities, facility staff that provide direct care services to the residents, and facility
 7.4 administration.

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

7.10 (1) resident name;

7.11 (2) date of birth;

7.12 (3) Social Security number;

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

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

7.16 (6) date of admission to the facility;

7.17 (7) all current diagnoses;

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

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

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

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

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

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

7.28 Subd. 5a. **Administrator and licensee responsibilities** responsibility to provide
 7.29 **notice**. At least 60 days before the proposed date of closing, ~~curtailment~~, reduction, or
 7.30 change in operations as agreed to in the plan, the licensee administrator shall send a
 7.31 written notice of closure ~~or curtailment~~, reduction, or change in operations to each resident
 7.32 being relocated, the resident's ~~family member or designated representative~~ responsible
 7.33 party, and the resident's managed care organization if it is known, the county social
 7.34 services agency, the commissioner of health, the commissioner of human services, the
 7.35 Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental
 7.36 Health and Developmental Disabilities, the resident's attending physician, and, in the case

8.1 of a complete facility closure, the Centers for Medicare and Medicaid Services regional
 8.2 office designated representative. The notice must include the following:

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

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

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

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

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

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

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

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

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

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

8.32 (2) the ~~certification level of the available beds;~~

8.33 (3) the ~~types of services available; and~~

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

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

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

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

9.21 Subd. 5e. **Licensee responsibility for site visits.** The licensee shall assist
 9.22 residents desiring to make site visits to facilities with available beds or other appropriate
 9.23 living options to which the resident may relocate, unless it is medically inadvisable, as
 9.24 documented by the attending physician in the resident's care record. The licensee shall
 9.25 ~~provide or arrange~~ make available to the resident at no charge transportation for up to
 9.26 three site visits to facilities or other living options within a ~~50-mile radius to which the~~
 9.27 ~~resident may relocate, or within a larger radius if no suitable options are available within~~
 9.28 ~~50 miles. The licensee shall provide available written materials to residents on a potential~~
 9.29 ~~new facility or living option~~ the county or contiguous counties.

9.30 Subd. 5f. **Licensee responsible responsibility for resident property, funds, and**
 9.31 **telephone service communication devices.** (a) The licensee shall complete an inventory
 9.32 of resident personal possessions and provide a copy of the final inventory to the resident
 9.33 and the resident's ~~designated representative~~ responsible party prior to relocation. The
 9.34 licensee shall be responsible for the transfer of the resident's possessions for all relocations
 9.35 ~~within a 50-mile radius of the facility, or within a larger radius if no suitable options are~~
 9.36 ~~available within 50 miles~~ to a selected new location within the county or contiguous

10.1 counties. The licensee shall complete the transfer of resident possessions in a timely
 10.2 manner, ~~but no later than the date of the actual physical relocation of the resident.~~

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

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

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

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

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

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

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

10.35 Subd. 6. **Responsibilities of licensee during relocation.** (a) The licensee shall, at
 10.36 no charge to the resident, make arrangements or provide for the transportation of residents

11.1 to the new facility or ~~placement within a 50-mile radius, or within a larger radius if no~~
 11.2 ~~suitable options are available within 50 miles~~ location within the county or contiguous
 11.3 counties. The licensee shall provide a staff person to accompany the resident during
 11.4 transportation to the new location within the county or contiguous counties, upon request
 11.5 of the resident, the resident's family, or ~~designated representative~~ responsible party. The
 11.6 discharge and relocation of residents must ~~comply with all applicable state and federal~~
 11.7 ~~requirements and~~ must be conducted in a safe, and orderly, ~~and~~ appropriate manner.
 11.8 The licensee must ensure that there is no disruption in providing meals, medications, or
 11.9 treatments of a resident during the relocation process.

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

- 11.17 (1) the relocation plan developed;
- 11.18 (2) the interdisciplinary team members; and
- 11.19 (3) the number of residents to be relocated.
- 11.20 (c) Subsequent status reports must identify:
 - 11.21 (1) any modifications to the plan;
 - 11.22 (2) any change of interdisciplinary team members;
 - 11.23 (3) the number of residents relocated;
 - 11.24 (4) the destination to which residents have been relocated;
 - 11.25 (5) the number of residents remaining to be relocated; and
 - 11.26 (6) issues or problems encountered during the process and resolution of these issues.

11.27 **Subd. 7. Responsibilities of licensee following relocation.** The licensee shall retain
 11.28 or make arrangements for the retention of all remaining resident records for the period
 11.29 required by law. The licensee shall provide the Department of Health access to these
 11.30 records. The licensee shall notify the Department of Health of the location of any resident
 11.31 records that have not been transferred to the new facility or other health care entity.

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

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

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

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

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

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

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

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

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

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

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

- 13.10 (1) assess the adjustment of the resident to the new placement;
- 13.11 (2) recommend services or methods to meet any special needs of the resident; and
- 13.12 (3) identify residents at risk.

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

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

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

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

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

13.28 Subd. 10. **Facility closure rate adjustment.** Upon the request of a closing facility,
 13.29 the commissioner of human services must allow the facility a closure rate adjustment equal
 13.30 to a 50 percent payment rate increase to reimburse relocation costs or other costs related to
 13.31 facility closure. This rate increase is effective on the date the facility's occupancy decreases
 13.32 to 90 percent of capacity days after the written notice of closure is distributed under
 13.33 subdivision 5 and shall remain in effect for a period of up to 60 days. The commissioner
 13.34 shall delay the implementation of rate adjustments under section 256B.437, subdivisions
 13.35 3, paragraph (b), and 6, paragraph (a), to offset the cost of this rate adjustment.

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

14.9 Sec. 4. Minnesota Statutes 2012, section 256B.057, subdivision 9, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15.34 (i) Nonpayment of the premium shall result in denial or termination of medical
15.35 assistance unless the person demonstrates good cause for nonpayment. Good cause exists
15.36 if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to

16.1 D, are met. Except when an installment agreement is accepted by the commissioner, all
 16.2 persons disenrolled for nonpayment of a premium must pay any past due premiums as well
 16.3 as current premiums due prior to being reenrolled. Nonpayment shall include payment with
 16.4 a returned, refused, or dishonored instrument. The commissioner may require a guaranteed
 16.5 form of payment as the only means to replace a returned, refused, or dishonored instrument.

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

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

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

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

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

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

16.24 (b) The commissioner may authorize:

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

16.28 (2) private duty nursing in combination with other home care services up to the total
 16.29 cost allowed under section 256B.0652, ~~subdivision 6~~ subdivisions 5 and 7;

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

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

17.12 Sec. 6. Minnesota Statutes 2012, section 256B.0911, subdivision 2b, is amended to read:

17.13 Subd. 2b. **Certified assessors.** (a) Each lead agency shall use certified assessors who
17.14 have completed training and the certification processes determined by the commissioner
17.15 in subdivision 2c. Certified assessors shall demonstrate best practices in assessment and
17.16 support planning including person-centered planning principals and have a common set
17.17 of skills that must ensure consistency and equitable access to services statewide. ~~A lead~~
17.18 ~~agency may choose, according to departmental policies, to contract with a qualified,~~
17.19 ~~certified assessor to conduct assessments and reassessments on behalf of the lead agency.~~

17.20 (b) Certified assessors are persons with a minimum of a bachelor's degree in social
17.21 work, nursing with a public health nursing certificate, or other closely related field
17.22 with at least one year of home and community-based experience, or a registered nurse
17.23 without public health certification with at least two years of home and community-based
17.24 experience that has received training and certification specific to assessment and
17.25 consultation for long-term care services in the state.

17.26 Sec. 7. Minnesota Statutes 2012, section 256B.0911, subdivision 3, is amended to read:

17.27 Subd. 3. **Long-term care consultation team.** (a) A long-term care consultation
17.28 team shall be established by the county board of commissioners. Two or more counties
17.29 may collaborate to establish a joint local consultation team or teams.

17.30 (b) Certified assessors must be part of a multidisciplinary long-term care consultation
17.31 team of professionals that includes public health nurses, social workers, and other
17.32 professionals as defined in subdivision 2b, paragraph (b). The team is responsible for
17.33 providing long-term care consultation services to all persons located in the county who
17.34 request the services, regardless of eligibility for Minnesota health care programs, except

18.1 for persons leaving regional treatment centers returning to the community when the
18.2 county of financial responsibility has been following the person's placement and has been
18.3 working with the person to arrange for discharge.

18.4 (c) The commissioner shall allow arrangements and make recommendations that
18.5 encourage counties and tribes to collaborate to establish joint local long-term care
18.6 consultation teams to ensure that long-term care consultations are done within the
18.7 timelines and parameters of the service. This includes integrated service models as
18.8 required in subdivision 1, paragraph (b).

18.9 (d) Tribes and health plans under contract with the commissioner must provide
18.10 long-term care consultation services as specified in the contract.

18.11 (e) The lead agency must provide the commissioner with an administrative contact
18.12 for communication purposes.

18.13 Sec. 8. Minnesota Statutes 2012, section 256B.0911, subdivision 3a, is amended to read:

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

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

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

18.34 (d) The assessment must be conducted in a face-to-face interview with the person
18.35 being assessed and the person's legal representative, and other individuals as requested by

19.1 the person, who can provide information on the needs, strengths, and preferences of the
19.2 person necessary to develop a community support plan that ensures the person's health and
19.3 safety, but who is not a provider of service or has any financial interest in the provision
19.4 of services. For persons who are to be assessed for elderly waiver customized living
19.5 services under section 256B.0915, with the permission of the person being assessed or
19.6 the person's designated or legal representative, the client's current or proposed provider
19.7 of services may submit a copy of the provider's nursing assessment or written report
19.8 outlining its recommendations regarding the client's care needs. The person conducting
19.9 the assessment will notify the provider of the date by which this information is to be
19.10 submitted. This information shall be provided to the person conducting the assessment
19.11 prior to the assessment. For a person who is to be assessed for waiver services under
19.12 section 256B.092 or 256B.49, with the permission of the person being assessed or the
19.13 person's designated legal representative, the person's current provider of services may
19.14 submit a written report outlining recommendations regarding the person's care needs
19.15 prepared by a direct service employee with a least 20 hours of service to that client. The
19.16 person conducting the assessment or reassessment must notify the provider of the date
19.17 by which this information is to be submitted. This information shall be provided to the
19.18 person conducting the assessment and the person or the person's legal representative, and
19.19 must be considered prior to the finalization of the assessment or reassessment.

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

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

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

19.34 (f) A person may request assistance in identifying community supports without
19.35 participating in a complete assessment. Upon a request for assistance identifying
19.36 community support, the person must be transferred or referred to long-term care options

20.1 counseling services available under sections 256.975, subdivision 7, and 256.01,
20.2 subdivision 24, for telephone assistance and follow up.

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

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

20.9 (1) written recommendations for community-based services and consumer-directed
20.10 options;

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

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

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

20.23 (5) information about Minnesota health care programs;

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

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

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

20.31 (9) the person's right to appeal the certified assessor's decision regarding eligibility
20.32 for all services and programs as defined in subdivision 1a, paragraphs (a), clause (7), and
20.33 (b), and incorporating the decision regarding the need for institutional level of care or the
20.34 lead agency's final decisions regarding public programs eligibility according to section
20.35 256.045, subdivision 3.

21.1 (i) Face-to-face assessment completed as part of eligibility determination for
21.2 the alternative care, elderly waiver, community alternatives for disabled individuals,
21.3 community alternative care, and brain injury waiver programs under sections 256B.0913,
21.4 256B.0915, and 256B.49 is valid to establish service eligibility for no more than 60
21.5 calendar days after the date of assessment.

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

21.14 Sec. 9. Minnesota Statutes 2012, section 256B.0911, subdivision 6, is amended to read:

21.15 Subd. 6. **Payment for long-term care consultation services.** (a) The total payment
21.16 for each county must be paid monthly by certified nursing facilities in the county. The
21.17 monthly amount to be paid by each nursing facility for each fiscal year must be determined
21.18 by dividing the county's annual allocation for long-term care consultation services by 12
21.19 to determine the monthly payment and allocating the monthly payment to each nursing
21.20 facility based on the number of licensed beds in the nursing facility. Payments to counties
21.21 in which there is no certified nursing facility must be made by increasing the payment
21.22 rate of the two facilities located nearest to the county seat.

21.23 (b) The commissioner shall include the total annual payment determined under
21.24 paragraph (a) for each nursing facility reimbursed under section 256B.431, 256B.434,
21.25 or 256B.441.

21.26 (c) In the event of the layaway, delicensure and decertification, or removal from
21.27 layaway of 25 percent or more of the beds in a facility, the commissioner may adjust
21.28 the per diem payment amount in paragraph (b) and may adjust the monthly payment
21.29 amount in paragraph (a). The effective date of an adjustment made under this paragraph
21.30 shall be on or after the first day of the month following the effective date of the layaway,
21.31 delicensure and decertification, or removal from layaway.

21.32 (d) Payments for long-term care consultation services are available to the county
21.33 or counties to cover staff salaries and expenses to provide the services described in
21.34 subdivision 1a. The county shall employ, ~~or contract with other agencies to employ,~~
21.35 within the limits of available funding, sufficient personnel to provide long-term care

22.1 consultation services while meeting the state's long-term care outcomes and objectives as
 22.2 defined in subdivision 1. The county shall be accountable for meeting local objectives
 22.3 as approved by the commissioner in the biennial home and community-based services
 22.4 quality assurance plan on a form provided by the commissioner.

22.5 (e) Notwithstanding section 256B.0641, overpayments attributable to payment of the
 22.6 screening costs under the medical assistance program may not be recovered from a facility.

22.7 (f) The commissioner of human services shall amend the Minnesota medical
 22.8 assistance plan to include reimbursement for the local consultation teams.

22.9 (g) Until the alternative payment methodology in paragraph (h) is implemented,
 22.10 the county may bill, as case management services, assessments, support planning, and
 22.11 follow-along provided to persons determined to be eligible for case management under
 22.12 Minnesota health care programs. No individual or family member shall be charged for an
 22.13 initial assessment or initial support plan development provided under subdivision 3a or 3b.

22.14 (h) The commissioner shall develop an alternative payment methodology for
 22.15 long-term care consultation services that includes the funding available under this
 22.16 subdivision, and sections 256B.092 and 256B.0659. In developing the new payment
 22.17 methodology, the commissioner shall consider the maximization of other funding sources,
 22.18 including federal funding, for all long-term care consultation and preadmission screening
 22.19 activity.

22.20 Sec. 10. Minnesota Statutes 2012, section 256B.092, subdivision 7, is amended to read:

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

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

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

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

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

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

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

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

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

23.34 Sec. 11. Minnesota Statutes 2012, section 256B.441, subdivision 1, is amended to read:

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

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

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

24.13 (d) Each cost reporting year shall begin on October 1 and end on the following
 24.14 September 30. Beginning in ~~2006~~ 2014, a statistical and cost report shall be filed by each
 24.15 nursing facility by ~~January 15~~ February 1. Notice of rates shall be distributed by August
 24.16 15 and the rates shall go into effect on October 1 for one year.

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

24.25 Sec. 12. Minnesota Statutes 2012, section 256B.441, subdivision 43, is amended to read:

24.26 Subd. 43. **Reporting of statistical and cost information.** (a) Beginning in 2006,
 24.27 all nursing facilities shall provide information annually to the commissioner on a form
 24.28 and in a manner determined by the commissioner. The commissioner may also require
 24.29 nursing facilities to provide statistical and cost information for a subset of the items in
 24.30 the annual report on a semiannual basis. Nursing facilities shall report only costs directly
 24.31 related to the operation of the nursing facility. The facility shall not include costs which
 24.32 are separately reimbursed by residents, medical assistance, or other payors. Allocations
 24.33 of costs from central, affiliated, or corporate office and related organization transactions
 24.34 shall be reported according to section 256B.432. Beginning with the September 30, 2013,
 24.35 reporting year, the commissioner may shall no longer grant to facilities one extension of

25.1 ~~up to 15 days for the filing of this report if the extension is requested by December 15 and~~
25.2 ~~the commissioner determines that the extension will not prevent the commissioner from~~
25.3 ~~establishing rates in a timely manner required by law~~ extensions to the filing deadline.

25.4 The commissioner may separately require facilities to submit in a manner specified by
25.5 the commissioner documentation of statistical and cost information included in the report
25.6 to ensure accuracy in establishing payment rates and to perform audit and appeal review
25.7 functions under this section. Facilities shall retain all records necessary to document
25.8 statistical and cost information on the report for a period of no less than seven years.

25.9 The commissioner may amend information in the report according to subdivision 47.

25.10 The commissioner may reject a report filed by a nursing facility under this section if the
25.11 commissioner determines that the report has been filed in a form that is incomplete or
25.12 inaccurate and the information is insufficient to establish accurate payment rates. In the
25.13 event that a complete report is not submitted in a timely manner, the commissioner shall
25.14 reduce the reimbursement payments to a nursing facility to 85 percent of amounts due
25.15 until the information is filed. The release of withheld payments shall be retroactive for
25.16 no more than 90 days. A nursing facility that does not submit a report or whose report is
25.17 filed in a timely manner but determined to be incomplete shall be given written notice that
25.18 a payment reduction is to be implemented and allowed ten days to complete the report
25.19 prior to any payment reduction. The commissioner may delay the payment withhold under
25.20 exceptional circumstances to be determined at the sole discretion of the commissioner.

25.21 (b) Nursing facilities may, within 12 months of the due date of a statistical and
25.22 cost report, file an amendment when errors or omissions in the annual statistical and
25.23 cost report are discovered and an amendment would result in a rate increase of at least
25.24 0.15 percent of the statewide weighted average operating payment rate and shall, at any
25.25 time, file an amendment which would result in a rate reduction of at least 0.15 percent of
25.26 the statewide weighted average operating payment rate. The commissioner shall make
25.27 retroactive adjustments to the total payment rate of a nursing facility if an amendment is
25.28 accepted. Where a retroactive adjustment is to be made as a result of an amended report,
25.29 audit findings, or other determination of an incorrect payment rate, the commissioner may
25.30 settle the payment error through a negotiated agreement with the facility and a gross
25.31 adjustment of the payments to the facility. Retroactive adjustments shall not be applied
25.32 to private pay residents. An error or omission for purposes of this item does not include
25.33 a nursing facility's determination that an election between permissible alternatives was
25.34 not advantageous and should be changed.

25.35 (c) If the commissioner determines that a nursing facility knowingly supplied
25.36 inaccurate or false information or failed to file an amendment to a statistical and cost report

26.1 that resulted in or would result in an overpayment, the commissioner shall immediately
26.2 adjust the nursing facility's payment rate and recover the entire overpayment. The
26.3 commissioner may also terminate the commissioner's agreement with the nursing facility
26.4 and prosecute under applicable state or federal law.

26.5 Sec. 13. Minnesota Statutes 2012, section 256B.441, subdivision 63, is amended to read:

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

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

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

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

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

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

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

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

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

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

27.5 Sec. 14. Minnesota Statutes 2012, section 256B.49, subdivision 14, is amended to read:

27.6 Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments
27.7 shall be conducted by certified assessors according to section 256B.0911, subdivision 2b.
27.8 The certified assessor, with the permission of the recipient or the recipient's designated
27.9 legal representative, may invite other individuals to attend the assessment. With the
27.10 permission of the recipient or the recipient's designated legal representative, the recipient's
27.11 current provider of services may submit a written report outlining their recommendations
27.12 regarding the recipient's care needs prepared by a direct service employee with at least
27.13 20 hours of service to that client. ~~The person conducting the assessment or reassessment~~
27.14 certified assessor must notify the provider of the date by which this information is to be
27.15 submitted. This information shall be provided to the ~~person conducting the assessment~~
27.16 certified assessor and the person or the person's legal representative and must be
27.17 considered prior to the finalization of the assessment or reassessment.

27.18 (b) There must be a determination that the client requires a hospital level of care or a
27.19 nursing facility level of care as defined in section 256B.0911, subdivision 4a, paragraph
27.20 (d), at initial and subsequent assessments to initiate and maintain participation in the
27.21 waiver program.

27.22 (c) Regardless of other assessments identified in section 144.0724, subdivision 4, as
27.23 appropriate to determine nursing facility level of care for purposes of medical assistance
27.24 payment for nursing facility services, only face-to-face assessments conducted according
27.25 to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care
27.26 determination or a nursing facility level of care determination must be accepted for
27.27 purposes of initial and ongoing access to waiver services payment.

27.28 (d) Recipients who are found eligible for home and community-based services under
27.29 this section before their 65th birthday may remain eligible for these services after their
27.30 65th birthday if they continue to meet all other eligibility factors.

27.31 (e) The commissioner shall develop criteria to identify recipients whose level of
27.32 functioning is reasonably expected to improve and reassess these recipients to establish
27.33 a baseline assessment. Recipients who meet these criteria must have a comprehensive
27.34 transitional service plan developed under subdivision 15, paragraphs (b) and (c), and be
27.35 reassessed every six months until there has been no significant change in the recipient's

28.1 functioning for at least 12 months. After there has been no significant change in the
28.2 recipient's functioning for at least 12 months, reassessments of the recipient's strengths,
28.3 informal support systems, and need for services shall be conducted at least every 12
28.4 months and at other times when there has been a significant change in the recipient's
28.5 functioning. Counties, case managers, and service providers are responsible for
28.6 conducting these reassessments and shall complete the reassessments out of existing funds.

28.7 Sec. 15. Minnesota Statutes 2012, section 256B.492, is amended to read:

28.8 **256B.492 HOME AND COMMUNITY-BASED SETTINGS FOR PEOPLE**
28.9 **WITH DISABILITIES.**

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

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

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

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

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

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

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

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

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

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

28.33 (c) The provisions of paragraphs (a) and (b) do not apply to any setting in which
28.34 individuals receive services under a home and community-based waiver as of July 1,
28.35 2012, and the setting does not meet the criteria of this section.

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

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

29.6 Sec. 16. Minnesota Statutes 2012, section 626.557, subdivision 10, is amended to read:

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

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

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

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

29.32 (2) the appointment of a guardian or conservator pursuant to sections 524.5-101 to
29.33 524.5-502, or guardianship or conservatorship pursuant to chapter 252A;

30.1 (3) replacement of a guardian or conservator suspected of maltreatment and
30.2 appointment of a suitable person as guardian or conservator, pursuant to sections
30.3 524.5-101 to 524.5-502; or

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

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

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

30.19 Sec. 17. **REPEALER.**

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

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

APPENDIX
Repealed Minnesota Statutes: 13-0155

256B.437 NURSING FACILITY VOLUNTARY CLOSURE; ALTERNATIVES.

Subd. 8. **County costs.** The commissioner of human services shall allocate funds for relocation costs incurred by counties for planned closures under this section as provided under section 144A.161, subdivision 11.

APPENDIX
Repealed Minnesota Session Laws: 13-0155

Laws 2012, chapter 216, article 11, section 31

Sec. 31. Minnesota Statutes 2010, section 256B.092, subdivision 7, is amended to read:

Subd. 7. **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, a certified assessor shall evaluate the need for an institutional level of care. The 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 certified assessor shall make an evaluation of need within five working days of an emergency admission of a person to an intermediate care facility for persons with developmental disabilities.