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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-SECOND SESSION

H. F. No. 1822

03/04/2021 Authored by Wolgamott
The bill was read for the first time and referred to the Committee on Health Finance and Policy
03/08/2021 By motion, recalled and re-referred to the Committee on Human Services Finance and Policy

1.1 A bill for an act

1.2 relating to human services; establishing certain temporary modifications to human
1.3 services programs in response to the COVID-19 pandemic as permanent changes;
1.4 amending Minnesota Statutes 2020, sections 256B.0625, subdivisions 20, 20b;
1.5 256B.0911, subdivisions 1a, 3a, 3f, 4d; 256B.0924, subdivisions 4a, 6; 256B.094,
1.6 subdivision 6; 256B.49, subdivision 14; 256I.05, subdivision 1c; 256J.09,
1.7 subdivision 3; 256J.45, subdivision 1; 256S.05, subdivision 2.

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

1.9 Section 1. Minnesota Statutes 2020, section 256B.0625, subdivision 20, is amended to
1.10 read:

1.11 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the
1.12 state agency, medical assistance covers case management services to persons with serious
1.13 and persistent mental illness and children with severe emotional disturbance. Services
1.14 provided under this section must meet the relevant standards in sections 245.461 to 245.4887,
1.15 the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts
1.16 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

1.17 (b) Entities meeting program standards set out in rules governing family community
1.18 support services as defined in section 245.4871, subdivision 17, are eligible for medical
1.19 assistance reimbursement for case management services for children with severe emotional
1.20 disturbance when these services meet the program standards in Minnesota Rules, parts
1.21 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

1.22 (c) Medical assistance and MinnesotaCare payment for mental health case management
1.23 shall be made on a monthly basis. In order to receive payment for an eligible child, the
1.24 provider must document at least a face-to-face contact or a contact by interactive video that

meets the requirements of subdivision 20b with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative or a contact by interactive video that meets the requirements of subdivision 20b; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact or a contact by interactive video that meets the requirements of subdivision 20b with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal

3.1 share, if any, shall be provided by the recipient's tribe. When this service is paid by the state
3.2 without a federal share through fee-for-service, 50 percent of the cost shall be provided by
3.3 the recipient's county of responsibility.

3.4 (i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance
3.5 and MinnesotaCare include mental health case management. When the service is provided
3.6 through prepaid capitation, the nonfederal share is paid by the state and the county pays no
3.7 share.

3.8 (j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider
3.9 that does not meet the reporting or other requirements of this section. The county of
3.10 responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency,
3.11 is responsible for any federal disallowances. The county or tribe may share this responsibility
3.12 with its contracted vendors.

3.13 (k) The commissioner shall set aside a portion of the federal funds earned for county
3.14 expenditures under this section to repay the special revenue maximization account under
3.15 section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

3.16 (1) the costs of developing and implementing this section; and

3.17 (2) programming the information systems.

3.18 (l) Payments to counties and tribal agencies for case management expenditures under
3.19 this section shall only be made from federal earnings from services provided under this
3.20 section. When this service is paid by the state without a federal share through fee-for-service,
3.21 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
3.22 shall include the federal earnings, the state share, and the county share.

3.23 (m) Case management services under this subdivision do not include therapy, treatment,
3.24 legal, or outreach services.

3.25 (n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
3.26 and the recipient's institutional care is paid by medical assistance, payment for case
3.27 management services under this subdivision is limited to the lesser of:

3.28 (1) the last 180 days of the recipient's residency in that facility and may not exceed more
3.29 than six months in a calendar year; or

3.30 (2) the limits and conditions which apply to federal Medicaid funding for this service.

3.31 (o) Payment for case management services under this subdivision shall not duplicate
3.32 payments made under other program authorities for the same purpose.

(p) If the recipient is receiving care in a hospital, nursing facility, or residential setting licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week, mental health targeted case management services must actively support identification of community alternatives for the recipient and discharge planning.

Sec. 2. Minnesota Statutes 2020, section 256B.0625, subdivision 20b, is amended to read:

Subd. 20b. **Mental health targeted case management through interactive video.** (a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment if:

(1) the person receiving targeted case management services is residing in:

(i) a hospital;

(ii) a nursing facility; or

(iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging establishment or lodging establishment that provides supportive services or health supervision services according to section 157.17 that is staffed 24 hours a day, seven days a week;

(2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian, the case management provider, and the provider operating the setting where the person is residing;

(3) the use of interactive video is approved as part of the person's written personal service or case plan, taking into consideration the person's vulnerability and active personal relationships; and

(4) interactive video is used for up to~~, but not more than, 50 percent of the minimum required face-to-face~~ two consecutive contacts following each in-person contact, not to exceed 50 percent of the minimum required face-to-face contact.

(b) The person receiving targeted case management or the person's legal guardian has the right to choose and consent to the use of interactive video under this subdivision and has the right to refuse the use of interactive video at any time.

(c) The commissioner shall establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of delivering the service via interactive video. The attestation may include that the case management provider has:

(1) written policies and procedures specific to interactive video services that are regularly reviewed and updated;

5.1 (2) policies and procedures that adequately address client safety before, during, and after
5.2 the interactive video services are rendered;

5.3 (3) established protocols addressing how and when to discontinue interactive video
5.4 services; and

5.5 (4) established a quality assurance process related to interactive video services.

5.6 (d) As a condition of payment, the targeted case management provider must document
5.7 the following for each occurrence of targeted case management provided by interactive
5.8 video:

5.9 (1) the time the service began and the time the service ended, including an a.m. and p.m.
5.10 designation;

5.11 (2) the basis for determining that interactive video is an appropriate and effective means
5.12 for delivering the service to the person receiving case management services;

5.13 (3) the mode of transmission of the interactive video services and records evidencing
5.14 that a particular mode of transmission was utilized;

5.15 (4) the location of the originating site and the distant site; and

5.16 (5) compliance with the criteria attested to by the targeted case management provider
5.17 as provided in paragraph (c).

5.18 Sec. 3. Minnesota Statutes 2020, section 256B.0911, subdivision 1a, is amended to read:

5.19 Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:

5.20 (a) Until additional requirements apply under paragraph (b), "long-term care consultation
5.21 services" means:

5.22 (1) intake for and access to assistance in identifying services needed to maintain an
5.23 individual in the most inclusive environment;

5.24 (2) providing recommendations for and referrals to cost-effective community services
5.25 that are available to the individual;

5.26 (3) development of an individual's person-centered community support plan;

5.27 (4) providing information regarding eligibility for Minnesota health care programs;

5.28 (5) ~~face-to-face~~ long-term care consultation assessments<u> conducted according to</u>
5.29 <u>subdivision 3a</u>, which may be completed in a hospital, nursing facility, intermediate care

6.1 facility for persons with developmental disabilities (ICF/DDs), regional treatment centers,
6.2 or the person's current or planned residence;

6.3 (6) determination of home and community-based waiver and other service eligibility as
6.4 required under chapter 256S and sections 256B.0913, 256B.092, and 256B.49, including
6.5 level of care determination for individuals who need an institutional level of care as
6.6 determined under subdivision 4e, based on a long-term care consultation assessment and
6.7 community support plan development, appropriate referrals to obtain necessary diagnostic
6.8 information, and including an eligibility determination for consumer-directed community
6.9 supports;

6.10 (7) providing recommendations for institutional placement when there are no
6.11 cost-effective community services available;

6.12 (8) providing access to assistance to transition people back to community settings after
6.13 institutional admission;

6.14 (9) providing information about competitive employment, with or without supports, for
6.15 school-age youth and working-age adults and referrals to the Disability Hub and Disability
6.16 Benefits 101 to ensure that an informed choice about competitive employment can be made.
6.17 For the purposes of this subdivision, "competitive employment" means work in the
6.18 competitive labor market that is performed on a full-time or part-time basis in an integrated
6.19 setting, and for which an individual is compensated at or above the minimum wage, but not
6.20 less than the customary wage and level of benefits paid by the employer for the same or
6.21 similar work performed by individuals without disabilities;

6.22 (10) providing information about independent living to ensure that an informed choice
6.23 about independent living can be made; and

6.24 (11) providing information about self-directed services and supports, including
6.25 self-directed funding options, to ensure that an informed choice about self-directed options
6.26 can be made.

6.27 (b) Upon statewide implementation of lead agency requirements in subdivisions 2b, 2c,
6.28 and 3a, "long-term care consultation services" also means:

6.29 (1) service eligibility determination for the following state plan services:

6.30 (i) personal care assistance services under section 256B.0625, subdivisions 19a and 19c;

6.31 (ii) consumer support grants under section 256.476; or

6.32 (iii) community first services and supports under section 256B.85;

7.1 (2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,
7.2 gaining access to:

7.3 (i) relocation targeted case management services available under section 256B.0621,
7.4 subdivision 2, clause (4);

7.5 (ii) case management services targeted to vulnerable adults or developmental disabilities
7.6 under section 256B.0924; and

7.7 (iii) case management services targeted to people with developmental disabilities under
7.8 Minnesota Rules, part 9525.0016;

7.9 (3) determination of eligibility for semi-independent living services under section
7.10 252.275; and

7.11 (4) obtaining necessary diagnostic information to determine eligibility under clauses (2)
7.12 and (3).

7.13 (c) "Long-term care options counseling" means the services provided by sections 256.01,
7.14 subdivision 24, and 256.975, subdivision 7, and also includes telephone assistance and
7.15 follow up once a long-term care consultation assessment has been completed.

7.16 (d) "Minnesota health care programs" means the medical assistance program under this
7.17 chapter and the alternative care program under section 256B.0913.

7.18 (e) "Lead agencies" means counties administering or tribes and health plans under
7.19 contract with the commissioner to administer long-term care consultation services.

7.20 (f) "Person-centered planning" is a process that includes the active participation of a
7.21 person in the planning of the person's services, including in making meaningful and informed
7.22 choices about the person's own goals, talents, and objectives, as well as making meaningful
7.23 and informed choices about the services the person receives, the settings in which the person
7.24 receives the services, and the setting in which the person lives.

7.25 (g) "Informed choice" means a voluntary choice of services, settings, living arrangement,
7.26 and work by a person from all available service and setting options based on accurate and
7.27 complete information concerning all available service and setting options and concerning
7.28 the person's own preferences, abilities, goals, and objectives. In order for a person to make
7.29 an informed choice, all available options must be developed and presented to the person in
7.30 a way the person can understand to empower the person to make fully informed choices.

7.31 (h) "Available service and setting options" or "available options," with respect to the
7.32 home and community-based waivers under chapter 256S and sections 256B.092 and 256B.49,

means all services and settings defined under the waiver plan for which a waiver applicant or waiver participant is eligible.

(i) "Independent living" means living in a setting that is not controlled by a provider.

Sec. 4. Minnesota Statutes 2020, section 256B.0911, subdivision 3a, is amended to read:

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

(b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified assessors to conduct the assessment. For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

(c) The MnCHOICES assessment provided by the commissioner to lead agencies must be used to complete a comprehensive, conversation-based, person-centered assessment. The assessment must include the health, psychological, functional, environmental, and social needs of the individual necessary to develop a person-centered community support plan that meets the individual's needs and preferences.

(d) Except as provided in paragraph (q), the assessment must be conducted by a certified assessor in a face-to-face conversational interview with the person being assessed. The person's legal representative must provide input during the assessment process and may do so remotely if requested. At the request of the person, other individuals may participate in the assessment to provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety. Except for legal representatives or family members invited by the person, persons participating in the assessment may not be a provider of service or have any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living or adult day services under chapter 256S, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting

9.1 the assessment must notify the provider of the date by which this information is to be
9.2 submitted. This information shall be provided to the person conducting the assessment prior
9.3 to the assessment. For a person who is to be assessed for waiver services under section
9.4 256B.092 or 256B.49, with the permission of the person being assessed or the person's
9.5 designated legal representative, the person's current provider of services may submit a
9.6 written report outlining recommendations regarding the person's care needs the person
9.7 completed in consultation with someone who is known to the person and has interaction
9.8 with the person on a regular basis. The provider must submit the report at least 60 days
9.9 before the end of the person's current service agreement. The certified assessor must consider
9.10 the content of the submitted report prior to finalizing the person's assessment or reassessment.

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

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

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

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

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

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

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

9.25 (iii) all available options for living arrangements;

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

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

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

9.31 (4) referral information; and

9.32 (5) informal caregiver supports, if applicable.

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

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

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

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

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

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

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

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

10.20 (1) written recommendations for community-based services and consumer-directed
10.21 options;

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

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

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

11.5 (5) information about Minnesota health care programs;

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

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

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

11.13 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
11.14 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
11.15 (8), and (b), and incorporating the decision regarding the need for institutional level of care
11.16 or the lead agency's final decisions regarding public programs eligibility according to section
11.17 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right
11.18 to the person and must visually point out where in the document the right to appeal is stated;
11.19 and

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

11.22 (k) ~~Face-to-face~~ Assessment completed as part of an eligibility determination for multiple
11.23 programs for the alternative care, elderly waiver, developmental disabilities, community
11.24 access for disability inclusion, community alternative care, and brain injury waiver programs
11.25 under chapter 256S and sections 256B.0913, 256B.092, and 256B.49 is valid to establish
11.26 service eligibility for no more than 60 calendar days after the date of assessment.

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

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

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

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

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

(q) All assessments performed according to this subdivision must be face-to-face unless the assessment is a reassessment meeting the requirements of this paragraph. Subject to federal approval, remote reassessments conducted by interactive video or telephone may substitute for face-to-face reassessments for services provided by alternative care under section 256B.0913, the elderly waiver under chapter 256S, the developmental disabilities waiver under section 256B.092, and the community access for disability inclusion, community alternative care, and brain injury waiver programs under section 256B.49. Remote reassessments may be substituted for two consecutive reassessments if followed by a face-to-face reassessment. A remote reassessment is permitted only if the person being reassessed, the person's legal representative, and the lead agency case manager all agree that there is no change in the person's condition, there is no need for a change in service,

13.1 and that a remote reassessment is appropriate. The person being reassessed, or the person's
13.2 legal representative, has the right to refuse a remote reassessment at any time. During a
13.3 remote reassessment, if the certified assessor determines in the assessor's sole judgment
13.4 that a remote reassessment is inappropriate, the certified assessor shall suspend the remote
13.5 reassessment and schedule a face-to-face reassessment to complete the reassessment. All
13.6 other requirements of a face-to-face reassessment apply to a remote reassessment.

13.7 Sec. 5. Minnesota Statutes 2020, section 256B.0911, subdivision 3f, is amended to read:

13.8 Subd. 3f. **Long-term care reassessments and community support plan updates.** (a)
13.9 Prior to a ~~face-to-face~~ reassessment, the certified assessor must review the person's most
13.10 recent assessment. Reassessments must be tailored using the professional judgment of the
13.11 assessor to the person's known needs, strengths, preferences, and circumstances.
13.12 Reassessments provide information to support the person's informed choice and opportunities
13.13 to express choice regarding activities that contribute to quality of life, as well as information
13.14 and opportunity to identify goals related to desired employment, community activities, and
13.15 preferred living environment. Reassessments require a review of the most recent assessment,
13.16 review of the current coordinated service and support plan's effectiveness, monitoring of
13.17 services, and the development of an updated person-centered community support plan.
13.18 Reassessments must verify continued eligibility, offer alternatives as warranted, and provide
13.19 an opportunity for quality assurance of service delivery. ~~Face-to-face~~ Reassessments must
13.20 be conducted annually or as required by federal and state laws and rules. For reassessments,
13.21 the certified assessor and the individual responsible for developing the coordinated service
13.22 and support plan must ensure the continuity of care for the person receiving services and
13.23 complete the updated community support plan and the updated coordinated service and
13.24 support plan no more than 60 days from the reassessment visit.

13.25 (b) The commissioner shall develop mechanisms for providers and case managers to
13.26 share information with the assessor to facilitate a reassessment and support planning process
13.27 tailored to the person's current needs and preferences.

13.28 Sec. 6. Minnesota Statutes 2020, section 256B.0911, subdivision 4d, is amended to read:

13.29 Subd. 4d. **Preadmission screening of individuals under 65 years of age.** (a) It is the
13.30 policy of the state of Minnesota to ensure that individuals with disabilities or chronic illness
13.31 are served in the most integrated setting appropriate to their needs and have the necessary
13.32 information to make informed choices about home and community-based service options.

(b) Individuals under 65 years of age who are admitted to a Medicaid-certified nursing facility must be screened prior to admission according to the requirements outlined in section 256.975, subdivisions 7a to 7c. This shall be provided by the Senior LinkAge Line as required under section 256.975, subdivision 7.

(c) Individuals under 65 years of age who are admitted to nursing facilities with only a telephone screening must receive a face-to-face assessment from the long-term care consultation team member of the county in which the facility is located or from the recipient's county case manager within the timeline established by the commissioner, based on review of data.

(d) At the face-to-face assessment, the long-term care consultation team member or county case manager must perform the activities required under subdivision 3b.

(e) For individuals under 21 years of age, a screening interview which recommends nursing facility admission must be face-to-face and approved by the commissioner before the individual is admitted to the nursing facility.

(f) In the event that an individual under 65 years of age is admitted to a nursing facility on an emergency basis, the Senior LinkAge Line must be notified of the admission on the next working day, and a face-to-face assessment as described in paragraph (c) must be conducted within the timeline established by the commissioner, based on review of data.

(g) At the face-to-face assessment, the long-term care consultation team member or the case manager must present information about home and community-based options, including consumer-directed options, so the individual can make informed choices. If the individual chooses home and community-based services, the long-term care consultation team member or case manager must complete a written relocation plan within 20 working days of the visit. The plan shall describe the services needed to move out of the facility and a time line for the move which is designed to ensure a smooth transition to the individual's home and community.

(h) An individual under 65 years of age residing in a nursing facility shall receive a ~~face-to-face assessment~~ reassessment at least every 12 months to review the person's service choices and available alternatives unless the individual indicates, in writing, that annual visits are not desired. In this case, the individual must receive a ~~face-to-face assessment~~ reassessment at least once every 36 months for the same purposes.

(i) Notwithstanding the provisions of subdivision 6, the commissioner may pay county agencies directly for ~~face-to-face~~ assessments for individuals under 65 years of age who are being considered for placement or residing in a nursing facility.

(j) Funding for preadmission screening follow-up shall be provided to the Disability Hub for the under-60 population by the Department of Human Services to cover options counseling salaries and expenses to provide the services described in subdivisions 7a to 7c. The Disability Hub shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide preadmission screening follow-up services and shall seek to maximize federal funding for the service as provided under section 256.01, subdivision 2, paragraph (aa).

Sec. 7. Minnesota Statutes 2020, section 256B.0924, subdivision 4a, is amended to read:

Subd. 4a. **Targeted case management through interactive video.** (a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment under subdivision 6 if:

(1) the person receiving targeted case management services is residing in:

(i) a hospital;

(ii) a nursing facility; or

(iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging establishment or lodging establishment that provides supportive services or health supervision services according to section 157.17 that is staffed 24 hours a day, seven days a week;

(2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian, the case management provider, and the provider operating the setting where the person is residing;

(3) the use of interactive video is approved as part of the person's written personal service or case plan; and

(4) interactive video is used for up to~~, but not more than, 50 percent of the minimum required face-to-face~~ two consecutive contacts following each in-person contact, not to exceed 50 percent of the minimum required face-to-face contact.

(b) The person receiving targeted case management or the person's legal guardian has the right to choose and consent to the use of interactive video under this subdivision and has the right to refuse the use of interactive video at any time.

(c) The commissioner shall establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of delivering the service via interactive video. The attestation may include that the case management provider has:

16.1 (1) written policies and procedures specific to interactive video services that are regularly
16.2 reviewed and updated;

16.3 (2) policies and procedures that adequately address client safety before, during, and after
16.4 the interactive video services are rendered;

16.5 (3) established protocols addressing how and when to discontinue interactive video
16.6 services; and

16.7 (4) established a quality assurance process related to interactive video services.

16.8 (d) As a condition of payment, the targeted case management provider must document
16.9 the following for each occurrence of targeted case management provided by interactive
16.10 video:

16.11 (1) the time the service began and the time the service ended, including an a.m. and p.m.
16.12 designation;

16.13 (2) the basis for determining that interactive video is an appropriate and effective means
16.14 for delivering the service to the person receiving case management services;

16.15 (3) the mode of transmission of the interactive video services and records evidencing
16.16 that a particular mode of transmission was utilized;

16.17 (4) the location of the originating site and the distant site; and

16.18 (5) compliance with the criteria attested to by the targeted case management provider
16.19 as provided in paragraph (c).

16.20 Sec. 8. Minnesota Statutes 2020, section 256B.0924, subdivision 6, is amended to read:

16.21 Subd. 6. **Payment for targeted case management.** (a) Medical assistance and
16.22 MinnesotaCare payment for targeted case management shall be made on a monthly basis.
16.23 In order to receive payment for an eligible adult, the provider must document at least one
16.24 contact per month and not more than two consecutive months without a face-to-face contact
16.25 or a contact by interactive video that meets the requirements of subdivision 4a with the adult
16.26 or the adult's legal representative, family, primary caregiver, or other relevant persons
16.27 identified as necessary to the development or implementation of the goals of the personal
16.28 service plan.

16.29 (b) Payment for targeted case management provided by county staff under this subdivision
16.30 shall be based on the monthly rate methodology under section 256B.094, subdivision 6,
16.31 paragraph (b), calculated as one combined average rate together with adult mental health
16.32 case management under section 256B.0625, subdivision 20, except for calendar year 2002.

17.1 In calendar year 2002, the rate for case management under this section shall be the same as
17.2 the rate for adult mental health case management in effect as of December 31, 2001. Billing
17.3 and payment must identify the recipient's primary population group to allow tracking of
17.4 revenues.

17.5 (c) Payment for targeted case management provided by county-contracted vendors shall
17.6 be based on a monthly rate negotiated by the host county. The negotiated rate must not
17.7 exceed the rate charged by the vendor for the same service to other payers. If the service is
17.8 provided by a team of contracted vendors, the county may negotiate a team rate with a
17.9 vendor who is a member of the team. The team shall determine how to distribute the rate
17.10 among its members. No reimbursement received by contracted vendors shall be returned
17.11 to the county, except to reimburse the county for advance funding provided by the county
17.12 to the vendor.

17.13 (d) If the service is provided by a team that includes contracted vendors and county staff,
17.14 the costs for county staff participation on the team shall be included in the rate for
17.15 county-provided services. In this case, the contracted vendor and the county may each
17.16 receive separate payment for services provided by each entity in the same month. In order
17.17 to prevent duplication of services, the county must document, in the recipient's file, the need
17.18 for team targeted case management and a description of the different roles of the team
17.19 members.

17.20 (e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
17.21 targeted case management shall be provided by the recipient's county of responsibility, as
17.22 defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
17.23 used to match other federal funds.

17.24 (f) The commissioner may suspend, reduce, or terminate reimbursement to a provider
17.25 that does not meet the reporting or other requirements of this section. The county of
17.26 responsibility, as defined in sections 256G.01 to 256G.12, is responsible for any federal
17.27 disallowances. The county may share this responsibility with its contracted vendors.

17.28 (g) The commissioner shall set aside five percent of the federal funds received under
17.29 this section for use in reimbursing the state for costs of developing and implementing this
17.30 section.

17.31 (h) Payments to counties for targeted case management expenditures under this section
17.32 shall only be made from federal earnings from services provided under this section. Payments
17.33 to contracted vendors shall include both the federal earnings and the county share.

18.1 (i) Notwithstanding section 256B.041, county payments for the cost of case management
18.2 services provided by county staff shall not be made to the commissioner of management
18.3 and budget. For the purposes of targeted case management services provided by county
18.4 staff under this section, the centralized disbursement of payments to counties under section
18.5 256B.041 consists only of federal earnings from services provided under this section.

18.6 (j) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
18.7 and the recipient's institutional care is paid by medical assistance, payment for targeted case
18.8 management services under this subdivision is limited to the lesser of:

18.9 (1) the last 180 days of the recipient's residency in that facility; or

18.10 (2) the limits and conditions which apply to federal Medicaid funding for this service.

18.11 (k) Payment for targeted case management services under this subdivision shall not
18.12 duplicate payments made under other program authorities for the same purpose.

18.13 (l) Any growth in targeted case management services and cost increases under this
18.14 section shall be the responsibility of the counties.

18.15 Sec. 9. Minnesota Statutes 2020, section 256B.094, subdivision 6, is amended to read:

18.16 Subd. 6. **Medical assistance reimbursement of case management services.** (a) Medical
18.17 assistance reimbursement for services under this section shall be made on a monthly basis.
18.18 Payment is based on face-to-face or telephone contacts between the case manager and the
18.19 client, client's family, primary caregiver, legal representative, or other relevant person
18.20 identified as necessary to the development or implementation of the goals of the individual
18.21 service plan regarding the status of the client, the individual service plan, or the goals for
18.22 the client. These contacts must meet the minimum standards in clauses (1) and (2):

18.23 (1) there must be a face-to-face contact at least once a month except as provided in clause
18.24 (2); and

18.25 (2) for a client placed outside of the county of financial responsibility, or a client served
18.26 by tribal social services placed outside the reservation, in an excluded time facility under
18.27 section 256G.02, subdivision 6, or through the Interstate Compact for the Placement of
18.28 Children, section 260.93, and the placement in either case is more than 60 miles beyond
18.29 the county or reservation boundaries, there must be at least one contact per month and not
18.30 more than two consecutive months without a face-to-face contact.

18.31 Face-to-face contacts under this paragraph may be conducted using interactive video for
18.32 up to two consecutive contacts following each in-person contact.

19.1 (b) Except as provided under paragraph (c), the payment rate is established using time
19.2 study data on activities of provider service staff and reports required under sections 245.482
19.3 and 256.01, subdivision 2, paragraph (p).

19.4 (c) Payments for tribes may be made according to section 256B.0625 or other relevant
19.5 federally approved rate setting methodology for child welfare targeted case management
19.6 provided by Indian health services and facilities operated by a tribe or tribal organization.

19.7 (d) Payment for case management provided by county or tribal social services contracted
19.8 vendors shall be based on a monthly rate negotiated by the host county or tribal social
19.9 services. The negotiated rate must not exceed the rate charged by the vendor for the same
19.10 service to other payers. If the service is provided by a team of contracted vendors, the county
19.11 or tribal social services may negotiate a team rate with a vendor who is a member of the
19.12 team. The team shall determine how to distribute the rate among its members. No
19.13 reimbursement received by contracted vendors shall be returned to the county or tribal social
19.14 services, except to reimburse the county or tribal social services for advance funding provided
19.15 by the county or tribal social services to the vendor.

19.16 (e) If the service is provided by a team that includes contracted vendors and county or
19.17 tribal social services staff, the costs for county or tribal social services staff participation in
19.18 the team shall be included in the rate for county or tribal social services provided services.
19.19 In this case, the contracted vendor and the county or tribal social services may each receive
19.20 separate payment for services provided by each entity in the same month. To prevent
19.21 duplication of services, each entity must document, in the recipient's file, the need for team
19.22 case management and a description of the roles and services of the team members.

19.23 (f) Separate payment rates may be established for different groups of providers to
19.24 maximize reimbursement as determined by the commissioner. The payment rate will be
19.25 reviewed annually and revised periodically to be consistent with the most recent time study
19.26 and other data. Payment for services will be made upon submission of a valid claim and
19.27 verification of proper documentation described in subdivision 7. Federal administrative
19.28 revenue earned through the time study, or under paragraph (c), shall be distributed according
19.29 to earnings, to counties, reservations, or groups of counties or reservations which have the
19.30 same payment rate under this subdivision, and to the group of counties or reservations which
19.31 are not certified providers under section 256F.10. The commissioner shall modify the
19.32 requirements set out in Minnesota Rules, parts 9550.0300 to 9550.0370, as necessary to
19.33 accomplish this.

20.1 Sec. 10. Minnesota Statutes 2020, section 256B.49, subdivision 14, is amended to read:

20.2 Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments shall be
20.3 conducted by certified assessors according to section 256B.0911, subdivision 2b.

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

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

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

20.16 Sec. 11. Minnesota Statutes 2020, section 256I.05, subdivision 1c, is amended to read:

20.17 Subd. 1c. **Rate increases.** An agency may not increase the rates negotiated for housing
20.18 support above those in effect on June 30, 1993, except as provided in paragraphs (a) to (f).

20.19 (a) An agency may increase the rates for room and board to the MSA equivalent rate
20.20 for those settings whose current rate is below the MSA equivalent rate.

20.21 (b) An agency may increase the rates for residents in adult foster care whose difficulty
20.22 of care has increased. The total housing support rate for these residents must not exceed the
20.23 maximum rate specified in subdivisions 1 and 1a. Agencies must not include nor increase
20.24 difficulty of care rates for adults in foster care whose difficulty of care is eligible for funding
20.25 by home and community-based waiver programs under title XIX of the Social Security Act.

20.26 (c) The room and board rates will be increased each year when the MSA equivalent rate
20.27 is adjusted for SSI cost-of-living increases by the amount of the annual SSI increase, less
20.28 the amount of the increase in the medical assistance personal needs allowance under section
20.29 256B.35.

20.30 (d) When housing support pays for an individual's room and board, or other costs
20.31 necessary to provide room and board, the rate payable to the residence must continue for
20.32 up to 18 calendar days per incident that the person is temporarily absent from the residence,

not to exceed 60 days in a calendar year, if the absence or absences are reported in advance to the county agency's social service staff. Advance reporting is not required for emergency absences due to crisis, illness, or injury. For purposes of maintaining housing while temporarily absent due to residential behavioral health treatment or health care treatment that requires admission to an inpatient hospital, nursing facility, or other health care facility, the room and board rate for an individual is payable beyond an 18-calendar-day absence period, not to exceed 150 days in a calendar year.

(e) For facilities meeting substantial change criteria within the prior year. Substantial change criteria exists if the establishment experiences a 25 percent increase or decrease in the total number of its beds, if the net cost of capital additions or improvements is in excess of 15 percent of the current market value of the residence, or if the residence physically moves, or changes its licensure, and incurs a resulting increase in operation and property costs.

(f) Until June 30, 1994, an agency may increase by up to five percent the total rate paid for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who reside in residences that are licensed by the commissioner of health as a boarding care home, but are not certified for the purposes of the medical assistance program. However, an increase under this clause must not exceed an amount equivalent to 65 percent of the 1991 medical assistance reimbursement rate for nursing home resident class A, in the geographic grouping in which the facility is located, as established under Minnesota Rules, parts 9549.0051 to 9549.0058.

Sec. 12. Minnesota Statutes 2020, section 256J.09, subdivision 3, is amended to read:

Subd. 3. **Submitting application form.** (a) A county agency must offer, in person or by mail, the application forms prescribed by the commissioner as soon as a person makes a written or oral inquiry. At that time, the county agency must:

(1) inform the person that assistance begins ~~with~~ on the date that the ~~signed~~ application is received by the county agency either as a written application; an application submitted by telephone; or an application submitted through Internet telepresence; or on the date that all eligibility criteria are met, whichever is later;

(2) inform a person that the person may submit the application by telephone or through Internet telepresence;

(3) inform a person that when the person submits the application by telephone or through Internet telepresence, the county agency must receive a signed written application within

30 days of the date that the person submitted the application by telephone or through Internet telepresence;

(4) inform the person that any delay in submitting the application will reduce the amount of assistance paid for the month of application;

~~(3)~~ (5) inform a person that the person may submit the application before an interview;

~~(4)~~ (6) explain the information that will be verified during the application process by the county agency as provided in section 256J.32;

~~(5)~~ (7) inform a person about the county agency's average application processing time and explain how the application will be processed under subdivision 5;

~~(6)~~ (8) explain how to contact the county agency if a person's application information changes and how to withdraw the application;

~~(7)~~ (9) inform a person that the next step in the application process is an interview and what a person must do if the application is approved including, but not limited to, attending orientation under section 256J.45 and complying with employment and training services requirements in sections 256J.515 to 256J.57;

~~(8)~~ (10) inform the person that ~~the~~ an interview must be conducted. The interview may be conducted face-to-face in the county office or at a location mutually agreed upon, through Internet telepresence, or ~~at a location mutually agreed upon~~ by telephone;

~~(9) inform a person who has received MFIP or DWP in the past 12 months of the option to have a face-to-face, Internet telepresence, or telephone interview;~~

~~(10)~~ (11) explain the child care and transportation services that are available under paragraph (c) to enable caregivers to attend the interview, screening, and orientation; and

~~(11)~~ (12) identify any language barriers and arrange for translation assistance during appointments, including, but not limited to, screening under subdivision 3a, orientation under section 256J.45, and assessment under section 256J.521.

(b) Upon receipt of a signed application, the county agency must stamp the date of receipt on the face of the application. The county agency must process the application within the time period required under subdivision 5. An applicant may withdraw the application at any time by giving written or oral notice to the county agency. The county agency must issue a written notice confirming the withdrawal. The notice must inform the applicant of the county agency's understanding that the applicant has withdrawn the application and no longer wants to pursue it. When, within ten days of the date of the agency's notice, an

23.1 applicant informs a county agency, in writing, that the applicant does not wish to withdraw
23.2 the application, the county agency must reinstate the application and finish processing the
23.3 application.

23.4 (c) Upon a participant's request, the county agency must arrange for transportation and
23.5 child care or reimburse the participant for transportation and child care expenses necessary
23.6 to enable participants to attend the screening under subdivision 3a and orientation under
23.7 section 256J.45.

23.8 Sec. 13. Minnesota Statutes 2020, section 256J.45, subdivision 1, is amended to read:

23.9 Subdivision 1. **County agency to provide orientation.** A county agency must provide
23.10 ~~a face-to-face~~ an orientation to each MFIP caregiver unless the caregiver is:

23.11 (1) a single parent, or one parent in a two-parent family, employed at least 35 hours per
23.12 week; or

23.13 (2) a second parent in a two-parent family who is employed for 20 or more hours per
23.14 week provided the first parent is employed at least 35 hours per week.

23.15 The county agency must inform caregivers who are not exempt under clause (1) or (2) that
23.16 failure to attend the orientation is considered an occurrence of noncompliance with program
23.17 requirements, and will result in the imposition of a sanction under section 256J.46. If the
23.18 client complies with the orientation requirement prior to the first day of the month in which
23.19 the grant reduction is proposed to occur, the orientation sanction shall be lifted.

23.20 Sec. 14. Minnesota Statutes 2020, section 256S.05, subdivision 2, is amended to read:

23.21 Subd. 2. **Nursing facility level of care determination required.** Notwithstanding other
23.22 assessments identified in section 144.0724, subdivision 4, only ~~face-to-face~~ assessments
23.23 conducted according to section 256B.0911, subdivisions 3, 3a, and 3b, that result in a nursing
23.24 facility level of care determination at initial and subsequent assessments shall be accepted
23.25 for purposes of a participant's initial and ongoing participation in the elderly waiver and a
23.26 service provider's access to service payments under this chapter.