

S.F. No. 2483 and H.F. No. 2911, which had been referred to the Chief Clerk for comparison, were examined and found to be not identical.

The following document shows the differences between S.F. No. 2483, the first engrossment, and H.F. No. 2911, the first engrossment.

May 3, 2018

Patrick D. Murphy
Chief Clerk, House of Representatives

Explanation of Comparison Reports

When a Senate File is received from the Senate, it is given its first reading and must be referred to the appropriate standing committee or division under Rule 1.11.

But if the House File companion of that Senate File has already been reported out of Committee and given its second reading and is on the General Register, the Senate File must be referred to the Chief Clerk for comparison pursuant to Rule 1.15.

The Chief Clerk reports whether the bills were found to be identical or not identical. Once the bills have been compared and the differences have been reported, the Senate File is given its second reading and is substituted for the House File. The House File is then considered withdrawn.

Pursuant to rule 3.33, if the bills are not identical and the chief author of the bill wishes to use the House language, the chief author must give notice of their intent to substitute the House language when the bill is placed on the Calendar for the Day or the Fiscal Calendar. If the chief author of the bill wishes to keep the Senate language, no action is required.

1.1 A bill for an act
 1.2 relating to human services; modifying adult foster care and community residential
 1.3 setting license capacity; modifying **various provisions governing** home and
 1.4 community-based services; amending Minnesota Statutes 2016, sections 245D.071,
 1.5 subdivision 5; 245D.091, subdivisions 2, 3, 4; Minnesota Statutes 2017 Supplement,
 1.6 sections 245A.03, subdivision 7; 245A.11, subdivision 2a; 245D.03, subdivision
 1.7 1; 256B.4914, subdivision 3.

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

1.9 Section 1. Minnesota Statutes 2017 Supplement, section 245A.03, subdivision 7, is
 1.10 amended to read:

1.11 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license
 1.12 for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult
 1.13 foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter
 1.14 for a physical location that will not be the primary residence of the license holder for the
 1.15 entire period of licensure. If a license is issued during this moratorium, and the license
 1.16 holder changes the license holder's primary residence away from the physical location of
 1.17 the foster care license, the commissioner shall revoke the license according to section
 1.18 245A.07. The commissioner shall not issue an initial license for a community residential
 1.19 setting licensed under chapter 245D. When approving an exception under this paragraph,
 1.20 the commissioner shall consider the resource need determination process in paragraph (h),
 1.21 the availability of foster care licensed beds in the geographic area in which the licensee
 1.22 seeks to operate, the results of a person's choices during their annual assessment and service
 1.23 plan review, and the recommendation of the local county board. The determination by the
 1.24 commissioner is final and not subject to appeal. Exceptions to the moratorium include:

1.25 (1) foster care settings that are required to be registered under chapter 144D;

2.1 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or
 2.2 community residential setting licenses replacing adult foster care licenses in existence on
 2.3 December 31, 2013, and determined to be needed by the commissioner under paragraph
 2.4 (b);

2.5 (3) new foster care licenses or community residential setting licenses determined to be
 2.6 needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD,
 2.7 or regional treatment center; restructuring of state-operated services that limits the capacity

1.1 A bill for an act
 1.2 relating to human services; modifying adult foster care and community residential
 1.3 setting license capacity; modifying home and community-based services **plan**
 1.4 **review and evaluation and intervention services; modifying requirements and**
 1.5 **timelines for completing community support plans and coordinated service and**
 1.6 **support plans; modifying housing support; directing the commissioner of human**
 1.7 **services to allow brain injury and community access for disability inclusion waivers**
 1.8 **customized living services provider to transfer capacity to up to three other housing**
 1.9 **with services settings located in Hennepin County; requiring a report; amending**
 1.10 Minnesota Statutes 2016, sections 245D.071, subdivision 5; 245D.091, subdivisions
 1.11 2, 3, 4; **256B.0659, subdivision 3a; 256B.0915, subdivision 6; 256B.092,**
 1.12 **subdivisions 1b, 1g; 256I.04, by adding subdivisions; Minnesota Statutes 2017**
 1.13 **Supplement, sections 245A.03, subdivision 7; 245A.11, subdivision 2a; 245D.03,**
 1.14 **subdivision 1; 256B.0911, subdivisions 1a, 3a, 3f, 5; 256B.49, subdivision 13;**
 1.15 **256B.4914, subdivision 3; 256I.03, subdivision 8; 256I.04, subdivision 2b.**

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

1.17 Section 1. Minnesota Statutes 2017 Supplement, section 245A.03, subdivision 7, is
 1.18 amended to read:

1.19 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license
 1.20 for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult
 1.21 foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter
 1.22 for a physical location that will not be the primary residence of the license holder for the
 1.23 entire period of licensure. If a license is issued during this moratorium, and the license
 1.24 holder changes the license holder's primary residence away from the physical location of
 1.25 the foster care license, the commissioner shall revoke the license according to section
 1.26 245A.07. The commissioner shall not issue an initial license for a community residential
 1.27 setting licensed under chapter 245D. When approving an exception under this paragraph,
 1.28 the commissioner shall consider the resource need determination process in paragraph (h),
 2.1 the availability of foster care licensed beds in the geographic area in which the licensee
 2.2 seeks to operate, the results of a person's choices during their annual assessment and service
 2.3 plan review, and the recommendation of the local county board. The determination by the
 2.4 commissioner is final and not subject to appeal. Exceptions to the moratorium include:

2.5 (1) foster care settings that are required to be registered under chapter 144D;

2.6 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or
 2.7 community residential setting licenses replacing adult foster care licenses in existence on
 2.8 December 31, 2013, and determined to be needed by the commissioner under paragraph
 2.9 (b);

2.10 (3) new foster care licenses or community residential setting licenses determined to be
 2.11 needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD,
 2.12 or regional treatment center; restructuring of state-operated services that limits the capacity

2.8 of state-operated facilities; or allowing movement to the community for people who no
 2.9 longer require the level of care provided in state-operated facilities as provided under section
 2.10 256B.092, subdivision 13, or 256B.49, subdivision 24;

2.11 (4) new foster care licenses or community residential setting licenses determined to be
 2.12 needed by the commissioner under paragraph (b) for persons requiring hospital level care;

2.13 (5) new foster care licenses or community residential setting licenses determined to be
 2.14 needed by the commissioner for the transition of people from personal care assistance to
 2.15 the home and community-based services;

2.16 (6) new foster care licenses or community residential setting licenses determined to be
 2.17 needed by the commissioner for the transition of people from the residential care waiver
 2.18 services to foster care services. This exception applies only when:

2.19 (i) the person's case manager provided the person with information about the choice of
 2.20 service, service provider, and location of service to help the person make an informed choice;
 2.21 and

2.22 (ii) the person's foster care services are less than or equal to the cost of the person's
 2.23 services delivered in the residential care waiver service setting as determined by the lead
 2.24 agency; ~~or~~

2.25 (7) new foster care licenses or community residential setting licenses for people receiving
 2.26 services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and
 2.27 for which a license is required. This exception does not apply to people living in their own
 2.28 home. For purposes of this clause, there is a presumption that a foster care or community
 2.29 residential setting license is required for services provided to three or more people in a
 2.30 dwelling unit when the setting is controlled by the provider. A license holder subject to this
 2.31 exception may rebut the presumption that a license is required by seeking a reconsideration
 2.32 of the commissioner's determination. The commissioner's disposition of a request for
 2.33 reconsideration is final and not subject to appeal under chapter 14. The exception is available
 2.34 until June 30, ~~2018~~ 2019. This exception is available when:

3.1 (i) the person's case manager provided the person with information about the choice of
 3.2 service, service provider, and location of service, including in the person's home, to help
 3.3 the person make an informed choice; and

3.4 (ii) the person's services provided in the licensed foster care or community residential
 3.5 setting are less than or equal to the cost of the person's services delivered in the unlicensed
 3.6 setting as determined by the lead agency; or

3.7 (8) a vacancy in a setting granted an exception under clause (7), may receive an exception
 3.8 created by a person receiving services under chapter 245D and residing in the unlicensed
 3.9 setting between January 1, 2017, and May 1, 2017, for which a vacancy occurs between
 3.10 January 1, 2017, and the date of the exception request. This exception is available when the
 3.11 lead agency provides documentation to the commissioner on the eligibility criteria being
 3.12 met. This exception is available until June 30, 2019.

2.13 of state-operated facilities; or allowing movement to the community for people who no
 2.14 longer require the level of care provided in state-operated facilities as provided under section
 2.15 256B.092, subdivision 13, or 256B.49, subdivision 24;

2.16 (4) new foster care licenses or community residential setting licenses determined to be
 2.17 needed by the commissioner under paragraph (b) for persons requiring hospital level care;

2.18 (5) new foster care licenses or community residential setting licenses determined to be
 2.19 needed by the commissioner for the transition of people from personal care assistance to
 2.20 the home and community-based services;

2.21 (6) new foster care licenses or community residential setting licenses determined to be
 2.22 needed by the commissioner for the transition of people from the residential care waiver
 2.23 services to foster care services. This exception applies only when:

2.24 (i) the person's case manager provided the person with information about the choice of
 2.25 service, service provider, and location of service to help the person make an informed choice;
 2.26 and

2.27 (ii) the person's foster care services are less than or equal to the cost of the person's
 2.28 services delivered in the residential care waiver service setting as determined by the lead
 2.29 agency; ~~or~~

2.30 (7) new foster care licenses or community residential setting licenses for people receiving
 2.31 services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and
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 2.33 home. For purposes of this clause, there is a presumption that a foster care or community
 3.1 residential setting license is required for services provided to three or more people in a
 3.2 dwelling unit when the setting is controlled by the provider. A license holder subject to this
 3.3 exception may rebut the presumption that a license is required by seeking a reconsideration
 3.4 of the commissioner's determination. The commissioner's disposition of a request for
 3.5 reconsideration is final and not subject to appeal under chapter 14. The exception is available
 3.6 until June 30, ~~2018~~ 2019. This exception is available when:

3.7 (i) the person's case manager provided the person with information about the choice of
 3.8 service, service provider, and location of service, including in the person's home, to help
 3.9 the person make an informed choice; and

3.10 (ii) the person's services provided in the licensed foster care or community residential
 3.11 setting are less than or equal to the cost of the person's services delivered in the unlicensed
 3.12 setting as determined by the lead agency; or

3.13 (8) a vacancy in a setting granted an exception under clause (7), created between January
 3.14 1, 2017, and the date of the exception request, by the departure of a person receiving services
 3.15 under chapter 245D and residing in the unlicensed setting between January 1, 2017, and
 3.16 May 1, 2017. This exception is available when the lead agency provides documentation to
 3.17 the commissioner on the eligibility criteria being met. This exception is available until June
 3.18 30, 2019.

3.13 (b) The commissioner shall determine the need for newly licensed foster care homes or
 3.14 community residential settings as defined under this subdivision. As part of the determination,
 3.15 the commissioner shall consider the availability of foster care capacity in the area in which
 3.16 the licensee seeks to operate, and the recommendation of the local county board. The
 3.17 determination by the commissioner must be final. A determination of need is not required
 3.18 for a change in ownership at the same address.

3.19 (c) When an adult resident served by the program moves out of a foster home that is not
 3.20 the primary residence of the license holder according to section 256B.49, subdivision 15,
 3.21 paragraph (f), or the adult community residential setting, the county shall immediately
 3.22 inform the Department of Human Services Licensing Division. The department may decrease
 3.23 the statewide licensed capacity for adult foster care settings.

3.24 (d) Residential settings that would otherwise be subject to the decreased license capacity
 3.25 established in paragraph (c) shall be exempt if the license holder's beds are occupied by
 3.26 residents whose primary diagnosis is mental illness and the license holder is certified under
 3.27 the requirements in subdivision 6a or section 245D.33.

3.28 (e) A resource need determination process, managed at the state level, using the available
 3.29 reports required by section 144A.351, and other data and information shall be used to
 3.30 determine where the reduced capacity determined under section 256B.493 will be
 3.31 implemented. The commissioner shall consult with the stakeholders described in section
 3.32 144A.351, and employ a variety of methods to improve the state's capacity to meet the
 3.33 informed decisions of those people who want to move out of corporate foster care or
 3.34 community residential settings, long-term service needs within budgetary limits, including
 4.1 seeking proposals from service providers or lead agencies to change service type, capacity,
 4.2 or location to improve services, increase the independence of residents, and better meet
 4.3 needs identified by the long-term services and supports reports and statewide data and
 4.4 information.

4.5 (f) At the time of application and reapplication for licensure, the applicant and the license
 4.6 holder that are subject to the moratorium or an exclusion established in paragraph (a) are
 4.7 required to inform the commissioner whether the physical location where the foster care
 4.8 will be provided is or will be the primary residence of the license holder for the entire period
 4.9 of licensure. If the primary residence of the applicant or license holder changes, the applicant
 4.10 or license holder must notify the commissioner immediately. The commissioner shall print
 4.11 on the foster care license certificate whether or not the physical location is the primary
 4.12 residence of the license holder.

4.13 (g) License holders of foster care homes identified under paragraph (f) that are not the
 4.14 primary residence of the license holder and that also provide services in the foster care home
 4.15 that are covered by a federally approved home and community-based services waiver, as
 4.16 authorized under section 256B.0915, 256B.092, or 256B.49, must inform the human services
 4.17 licensing division that the license holder provides or intends to provide these waiver-funded
 4.18 services.

3.19 (b) The commissioner shall determine the need for newly licensed foster care homes or
 3.20 community residential settings as defined under this subdivision. As part of the determination,
 3.21 the commissioner shall consider the availability of foster care capacity in the area in which
 3.22 the licensee seeks to operate, and the recommendation of the local county board. The
 3.23 determination by the commissioner must be final. A determination of need is not required
 3.24 for a change in ownership at the same address.

3.25 (c) When an adult resident served by the program moves out of a foster home that is not
 3.26 the primary residence of the license holder according to section 256B.49, subdivision 15,
 3.27 paragraph (f), or the adult community residential setting, the county shall immediately
 3.28 inform the Department of Human Services Licensing Division. The department may decrease
 3.29 the statewide licensed capacity for adult foster care settings.

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 3.32 residents whose primary diagnosis is mental illness and the license holder is certified under
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 4.8 seeking proposals from service providers or lead agencies to change service type, capacity,
 4.9 or location to improve services, increase the independence of residents, and better meet
 4.10 needs identified by the long-term services and supports reports and statewide data and
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 4.13 holder that are subject to the moratorium or an exclusion established in paragraph (a) are
 4.14 required to inform the commissioner whether the physical location where the foster care
 4.15 will be provided is or will be the primary residence of the license holder for the entire period
 4.16 of licensure. If the primary residence of the applicant or license holder changes, the applicant
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 4.22 that are covered by a federally approved home and community-based services waiver, as
 4.23 authorized under section 256B.0915, 256B.092, or 256B.49, must inform the human services
 4.24 licensing division that the license holder provides or intends to provide these waiver-funded
 4.25 services.

4.19 (h) The commissioner may adjust capacity to address needs identified in section
4.20 144A.351. Under this authority, the commissioner may approve new licensed settings or
4.21 delicense existing settings. Delicensing of settings will be accomplished through a process
4.22 identified in section 256B.493. Annually, by August 1, the commissioner shall provide
4.23 information and data on capacity of licensed long-term services and supports, actions taken
4.24 under the subdivision to manage statewide long-term services and supports resources, and
4.25 any recommendations for change to the legislative committees with jurisdiction over the
4.26 health and human services budget.

4.27 (i) The commissioner must notify a license holder when its corporate foster care or
4.28 community residential setting licensed beds are reduced under this section. The notice of
4.29 reduction of licensed beds must be in writing and delivered to the license holder by certified
4.30 mail or personal service. The notice must state why the licensed beds are reduced and must
4.31 inform the license holder of its right to request reconsideration by the commissioner. The
4.32 license holder's request for reconsideration must be in writing. If mailed, the request for
4.33 reconsideration must be postmarked and sent to the commissioner within 20 calendar days
4.34 after the license holder's receipt of the notice of reduction of licensed beds. If a request for
5.1 reconsideration is made by personal service, it must be received by the commissioner within
5.2 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

5.3 (j) The commissioner shall not issue an initial license for children's residential treatment
5.4 services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter
5.5 for a program that Centers for Medicare and Medicaid Services would consider an institution
5.6 for mental diseases. Facilities that serve only private pay clients are exempt from the
5.7 moratorium described in this paragraph. The commissioner has the authority to manage
5.8 existing statewide capacity for children's residential treatment services subject to the
5.9 moratorium under this paragraph and may issue an initial license for such facilities if the
5.10 initial license would not increase the statewide capacity for children's residential treatment
5.11 services subject to the moratorium under this paragraph.

5.12 Sec. 2. Minnesota Statutes 2017 Supplement, section 245A.11, subdivision 2a, is amended
5.13 to read:

5.14 Subd. 2a. **Adult foster care and community residential setting license capacity.** (a)
5.15 The commissioner shall issue adult foster care and community residential setting licenses
5.16 with a maximum licensed capacity of four beds, including nonstaff roomers and boarders,
5.17 except that the commissioner may issue a license with a capacity of five beds, including
5.18 roomers and boarders, according to paragraphs (b) to (g).

5.19 (b) The license holder may have a maximum license capacity of five if all persons in
5.20 care are age 55 or over and do not have a serious and persistent mental illness or a
5.21 developmental disability.

5.22 (c) The commissioner may grant variances to paragraph (b) to allow a facility with a
5.23 licensed capacity of up to five persons to admit an individual under the age of 55 if the

4.26 (h) The commissioner may adjust capacity to address needs identified in section
4.27 144A.351. Under this authority, the commissioner may approve new licensed settings or
4.28 delicense existing settings. Delicensing of settings will be accomplished through a process
4.29 identified in section 256B.493. Annually, by August 1, the commissioner shall provide
4.30 information and data on capacity of licensed long-term services and supports, actions taken
4.31 under the subdivision to manage statewide long-term services and supports resources, and
4.32 any recommendations for change to the legislative committees with jurisdiction over the
4.33 health and human services budget.

4.34 (i) The commissioner must notify a license holder when its corporate foster care or
4.35 community residential setting licensed beds are reduced under this section. The notice of
5.1 reduction of licensed beds must be in writing and delivered to the license holder by certified
5.2 mail or personal service. The notice must state why the licensed beds are reduced and must
5.3 inform the license holder of its right to request reconsideration by the commissioner. The
5.4 license holder's request for reconsideration must be in writing. If mailed, the request for
5.5 reconsideration must be postmarked and sent to the commissioner within 20 calendar days
5.6 after the license holder's receipt of the notice of reduction of licensed beds. If a request for
5.7 reconsideration is made by personal service, it must be received by the commissioner within
5.8 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

5.9 (j) The commissioner shall not issue an initial license for children's residential treatment
5.10 services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter
5.11 for a program that Centers for Medicare and Medicaid Services would consider an institution
5.12 for mental diseases. Facilities that serve only private pay clients are exempt from the
5.13 moratorium described in this paragraph. The commissioner has the authority to manage
5.14 existing statewide capacity for children's residential treatment services subject to the
5.15 moratorium under this paragraph and may issue an initial license for such facilities if the
5.16 initial license would not increase the statewide capacity for children's residential treatment
5.17 services subject to the moratorium under this paragraph.

5.18 **EFFECTIVE DATE. This section is effective June 29, 2018.**

5.19 Sec. 2. Minnesota Statutes 2017 Supplement, section 245A.11, subdivision 2a, is amended
5.20 to read:

5.21 Subd. 2a. **Adult foster care and community residential setting license capacity.** (a)
5.22 The commissioner shall issue adult foster care and community residential setting licenses
5.23 with a maximum licensed capacity of four beds, including nonstaff roomers and boarders,
5.24 except that the commissioner may issue a license with a capacity of five beds, including
5.25 roomers and boarders, according to paragraphs (b) to (g).

5.26 (b) The license holder may have a maximum license capacity of five if all persons in
5.27 care are age 55 or over and do not have a serious and persistent mental illness or a
5.28 developmental disability.

5.29 (c) The commissioner may grant variances to paragraph (b) to allow a facility with a
5.30 licensed capacity of up to five persons to admit an individual under the age of 55 if the

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5.24 variance complies with section 245A.04, subdivision 9, and approval of the variance is
5.25 recommended by the county in which the licensed facility is located.

5.26 (d) The commissioner may grant variances to paragraph (a) to allow the use of an
5.27 additional bed, up to five, for emergency crisis services for a person with serious and
5.28 persistent mental illness or a developmental disability, regardless of age, if the variance
5.29 complies with section 245A.04, subdivision 9, and approval of the variance is recommended
5.30 by the county in which the licensed facility is located.

5.31 (e) The commissioner may grant a variance to paragraph (b) to allow for the use of an
5.32 additional bed, up to five, for respite services, as defined in section 245A.02, for persons
5.33 with disabilities, regardless of age, if the variance complies with sections 245A.03,
6.1 subdivision 7, and 245A.04, subdivision 9, and approval of the variance is recommended
6.2 by the county in which the licensed facility is located. Respite care may be provided under
6.3 the following conditions:

6.4 (1) staffing ratios cannot be reduced below the approved level for the individuals being
6.5 served in the home on a permanent basis;

6.6 (2) no more than two different individuals can be accepted for respite services in any
6.7 calendar month and the total respite days may not exceed 120 days per program in any
6.8 calendar year;

6.9 (3) the person receiving respite services must have his or her own bedroom, which could
6.10 be used for alternative purposes when not used as a respite bedroom, and cannot be the
6.11 room of another person who lives in the facility; and

6.12 (4) individuals living in the facility must be notified when the variance is approved. The
6.13 provider must give 60 days' notice in writing to the residents and their legal representatives
6.14 prior to accepting the first respite placement. Notice must be given to residents at least two
6.15 days prior to service initiation, or as soon as the license holder is able if they receive notice
6.16 of the need for respite less than two days prior to initiation, each time a respite client will
6.17 be served, unless the requirement for this notice is waived by the resident or legal guardian.

6.18 (f) The commissioner may issue an adult foster care or community residential setting
6.19 license with a capacity of five adults if the fifth bed does not increase the overall statewide
6.20 capacity of licensed adult foster care or community residential setting beds in homes that
6.21 are not the primary residence of the license holder, as identified in a plan submitted to the
6.22 commissioner by the county, when the capacity is recommended by the county licensing
6.23 agency of the county in which the facility is located and if the recommendation verifies
6.24 that:

6.25 (1) the facility meets the physical environment requirements in the adult foster care
6.26 licensing rule;

6.27 (2) the five-bed living arrangement is specified for each resident in the resident's:

6.28 (i) individualized plan of care;

6.29 (ii) individual service plan under section 256B.092, subdivision 1b, if required; or

5.31 variance complies with section 245A.04, subdivision 9, and approval of the variance is
5.32 recommended by the county in which the licensed facility is located.

6.1 (d) The commissioner may grant variances to paragraph (a) to allow the use of an
6.2 additional bed, up to five, for emergency crisis services for a person with serious and
6.3 persistent mental illness or a developmental disability, regardless of age, if the variance
6.4 complies with section 245A.04, subdivision 9, and approval of the variance is recommended
6.5 by the county in which the licensed facility is located.

6.6 (e) The commissioner may grant a variance to paragraph (b) to allow for the use of an
6.7 additional bed, up to five, for respite services, as defined in section 245A.02, for persons
6.8 with disabilities, regardless of age, if the variance complies with sections 245A.03,
6.9 subdivision 7, and 245A.04, subdivision 9, and approval of the variance is recommended
6.10 by the county in which the licensed facility is located. Respite care may be provided under
6.11 the following conditions:

6.12 (1) staffing ratios cannot be reduced below the approved level for the individuals being
6.13 served in the home on a permanent basis;

6.14 (2) no more than two different individuals can be accepted for respite services in any
6.15 calendar month and the total respite days may not exceed 120 days per program in any
6.16 calendar year;

6.17 (3) the person receiving respite services must have his or her own bedroom, which could
6.18 be used for alternative purposes when not used as a respite bedroom, and cannot be the
6.19 room of another person who lives in the facility; and

6.20 (4) individuals living in the facility must be notified when the variance is approved. The
6.21 provider must give 60 days' notice in writing to the residents and their legal representatives
6.22 prior to accepting the first respite placement. Notice must be given to residents at least two
6.23 days prior to service initiation, or as soon as the license holder is able if they receive notice
6.24 of the need for respite less than two days prior to initiation, each time a respite client will
6.25 be served, unless the requirement for this notice is waived by the resident or legal guardian.

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6.27 license with a capacity of five adults if the fifth bed does not increase the overall statewide
6.28 capacity of licensed adult foster care or community residential setting beds in homes that
6.29 are not the primary residence of the license holder, as identified in a plan submitted to the
6.30 commissioner by the county, when the capacity is recommended by the county licensing
6.31 agency of the county in which the facility is located and if the recommendation verifies
6.32 that:

6.33 (1) the facility meets the physical environment requirements in the adult foster care
6.34 licensing rule;

7.1 (2) the five-bed living arrangement is specified for each resident in the resident's:

7.2 (i) individualized plan of care;

7.3 (ii) individual service plan under section 256B.092, subdivision 1b, if required; or

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6.30 (iii) individual resident placement agreement under Minnesota Rules, part 9555.5105,
6.31 subpart 19, if required;

7.1 (3) the license holder obtains written and signed informed consent from each resident
7.2 or resident's legal representative documenting the resident's informed choice to remain
7.3 living in the home and that the resident's refusal to consent would not have resulted in
7.4 service termination; and

7.5 (4) the facility was licensed for adult foster care before ~~March 1, 2011~~ June 30, 2016.

7.6 (g) The commissioner shall not issue a new adult foster care license under paragraph (f)
7.7 after June 30, ~~2019~~ 2021. The commissioner shall allow a facility with an adult foster care
7.8 license issued under paragraph (f) before June 30, ~~2019~~ 2021, to continue with a capacity
7.9 of five adults if the license holder continues to comply with the requirements in paragraph
7.10 (f).

7.11 Sec. 3. Minnesota Statutes 2017 Supplement, section 245D.03, subdivision 1, is amended
7.12 to read:

7.13 Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of home
7.14 and community-based services to persons with disabilities and persons age 65 and older
7.15 pursuant to this chapter. The licensing standards in this chapter govern the provision of
7.16 basic support services and intensive support services.

7.17 (b) Basic support services provide the level of assistance, supervision, and care that is
7.18 necessary to ensure the health and welfare of the person and do not include services that
7.19 are specifically directed toward the training, treatment, habilitation, or rehabilitation of the
7.20 person. Basic support services include:

7.21 (1) in-home and out-of-home respite care services as defined in section 245A.02,
7.22 subdivision 15, and under the brain injury, community alternative care, community access
7.23 for disability inclusion, developmental disability, and elderly waiver plans, excluding
7.24 out-of-home respite care provided to children in a family child foster care home licensed
7.25 under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care license
7.26 holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7, and 8,
7.27 or successor provisions; and section 245D.061 or successor provisions, which must be
7.28 stipulated in the statement of intended use required under Minnesota Rules, part 2960.3000,
7.29 subpart 4;

7.30 (2) adult companion services as defined under the brain injury, community access for
7.31 disability inclusion, community alternative care, and elderly waiver plans, excluding adult
7.32 companion services provided under the Corporation for National and Community Services
8.1 Senior Companion Program established under the Domestic Volunteer Service Act of 1973,
8.2 Public Law 98-288;

8.3 (3) personal support as defined under the developmental disability waiver plan;

8.4 (4) 24-hour emergency assistance, personal emergency response as defined under the
8.5 community access for disability inclusion and developmental disability waiver plans;

7.4 (iii) individual resident placement agreement under Minnesota Rules, part 9555.5105,
7.5 subpart 19, if required;

7.6 (3) the license holder obtains written and signed informed consent from each resident
7.7 or resident's legal representative documenting the resident's informed choice to remain
7.8 living in the home and that the resident's refusal to consent would not have resulted in
7.9 service termination; and

7.10 (4) the facility was licensed for adult foster care before ~~March 1, 2011~~ June 30, 2016.

7.11 (g) The commissioner shall not issue a new adult foster care license under paragraph (f)
7.12 after June 30, ~~2019~~ 2021. The commissioner shall allow a facility with an adult foster care
7.13 license issued under paragraph (f) before June 30, ~~2019~~ 2021, to continue with a capacity
7.14 of five adults if the license holder continues to comply with the requirements in paragraph
7.15 (f).

7.16 Sec. 3. Minnesota Statutes 2017 Supplement, section 245D.03, subdivision 1, is amended
7.17 to read:

7.18 Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of home
7.19 and community-based services to persons with disabilities and persons age 65 and older
7.20 pursuant to this chapter. The licensing standards in this chapter govern the provision of
7.21 basic support services and intensive support services.

7.22 (b) Basic support services provide the level of assistance, supervision, and care that is
7.23 necessary to ensure the health and welfare of the person and do not include services that
7.24 are specifically directed toward the training, treatment, habilitation, or rehabilitation of the
7.25 person. Basic support services include:

7.26 (1) in-home and out-of-home respite care services as defined in section 245A.02,
7.27 subdivision 15, and under the brain injury, community alternative care, community access
7.28 for disability inclusion, developmental disability, and elderly waiver plans, excluding
7.29 out-of-home respite care provided to children in a family child foster care home licensed
7.30 under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care license
7.31 holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7, and 8,
7.32 or successor provisions; and section 245D.061 or successor provisions, which must be
8.1 stipulated in the statement of intended use required under Minnesota Rules, part 2960.3000,
8.2 subpart 4;

8.3 (2) adult companion services as defined under the brain injury, community access for
8.4 disability inclusion, community alternative care, and elderly waiver plans, excluding adult
8.5 companion services provided under the Corporation for National and Community Services
8.6 Senior Companion Program established under the Domestic Volunteer Service Act of 1973,
8.7 Public Law 98-288;

8.8 (3) personal support as defined under the developmental disability waiver plan;

8.9 (4) 24-hour emergency assistance, personal emergency response as defined under the
8.10 community access for disability inclusion and developmental disability waiver plans;

8.6 (5) night supervision services as defined under the brain injury, community access for
 8.7 disability inclusion, community alternative care, and developmental disability waiver plan
 8.8 plans;

8.9 (6) homemaker services as defined under the community access for disability inclusion,
 8.10 brain injury, community alternative care, developmental disability, and elderly waiver plans,
 8.11 excluding providers licensed by the Department of Health under chapter 144A and those
 8.12 providers providing cleaning services only; and

8.13 (7) individual community living support under section 256B.0915, subdivision 3j.

8.14 (c) Intensive support services provide assistance, supervision, and care that is necessary
 8.15 to ensure the health and welfare of the person and services specifically directed toward the
 8.16 training, habilitation, or rehabilitation of the person. Intensive support services include:

8.17 (1) intervention services, including:

8.18 (i) ~~behavioral~~ positive support services as defined under the brain injury ~~and~~, community
 8.19 access for disability inclusion, community alternative care, and developmental disability
 8.20 waiver plans;

8.21 (ii) in-home or out-of-home crisis respite services as defined under the brain injury,
 8.22 community access for disability inclusion, community alternative care, and developmental
 8.23 disability waiver plan plans; and

8.24 (iii) specialist services as defined under the current brain injury, community access for
 8.25 disability inclusion, community alternative care, and developmental disability waiver plan
 8.26 plans;

8.27 (2) in-home support services, including:

8.28 (i) in-home family support and supported living services as defined under the
 8.29 developmental disability waiver plan;

8.30 (ii) independent living services training as defined under the brain injury and community
 8.31 access for disability inclusion waiver plans;

9.1 (iii) semi-independent living services; and

9.2 (iv) individualized home supports services as defined under the brain injury, community
 9.3 alternative care, and community access for disability inclusion waiver plans;

9.4 (3) residential supports and services, including:

9.5 (i) supported living services as defined under the developmental disability waiver plan
 9.6 provided in a family or corporate child foster care residence, a family adult foster care
 9.7 residence, a community residential setting, or a supervised living facility;

9.8 (ii) foster care services as defined in the brain injury, community alternative care, and
 9.9 community access for disability inclusion waiver plans provided in a family or corporate
 9.10 child foster care residence, a family adult foster care residence, or a community residential
 9.11 setting; and

8.11 (5) night supervision services as defined under the brain injury, community access for
 8.12 disability inclusion, community alternative care, and developmental disability waiver plan
 8.13 plans;

8.14 (6) homemaker services as defined under the community access for disability inclusion,
 8.15 brain injury, community alternative care, developmental disability, and elderly waiver plans,
 8.16 excluding providers licensed by the Department of Health under chapter 144A and those
 8.17 providers providing cleaning services only; and

8.18 (7) individual community living support under section 256B.0915, subdivision 3j.

8.19 (c) Intensive support services provide assistance, supervision, and care that is necessary
 8.20 to ensure the health and welfare of the person and services specifically directed toward the
 8.21 training, habilitation, or rehabilitation of the person. Intensive support services include:

8.22 (1) intervention services, including:

8.23 (i) ~~behavioral~~ positive support services as defined under the brain injury ~~and~~, community
 8.24 access for disability inclusion, community alternative care, and developmental disability
 8.25 waiver plans;

8.26 (ii) in-home or out-of-home crisis respite services as defined under the brain injury,
 8.27 community access for disability inclusion, community alternative care, and developmental
 8.28 disability waiver plan plans; and

8.29 (iii) specialist services as defined under the current brain injury, community access for
 8.30 disability inclusion, community alternative care, and developmental disability waiver plan
 8.31 plans;

8.32 (2) in-home support services, including:

9.1 (i) in-home family support and supported living services as defined under the
 9.2 developmental disability waiver plan;

9.3 (ii) independent living services training as defined under the brain injury and community
 9.4 access for disability inclusion waiver plans;

9.5 (iii) semi-independent living services; and

9.6 (iv) individualized home supports services as defined under the brain injury, community
 9.7 alternative care, and community access for disability inclusion waiver plans;

9.8 (3) residential supports and services, including:

9.9 (i) supported living services as defined under the developmental disability waiver plan
 9.10 provided in a family or corporate child foster care residence, a family adult foster care
 9.11 residence, a community residential setting, or a supervised living facility;

9.12 (ii) foster care services as defined in the brain injury, community alternative care, and
 9.13 community access for disability inclusion waiver plans provided in a family or corporate
 9.14 child foster care residence, a family adult foster care residence, or a community residential
 9.15 setting; and

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9.12 (iii) residential services provided to more than four persons with developmental
9.13 disabilities in a supervised living facility, including ICFs/DD;
9.14 (4) day services, including:
9.15 (i) structured day services as defined under the brain injury waiver plan;
9.16 (ii) day training and habilitation services under sections 252.41 to 252.46, and as defined
9.17 under the developmental disability waiver plan; and
9.18 (iii) prevocational services as defined under the brain injury and community access for
9.19 disability inclusion waiver plans; and
9.20 (5) employment exploration services as defined under the brain injury, community
9.21 alternative care, community access for disability inclusion, and developmental disability
9.22 waiver plans;
9.23 (6) employment development services as defined under the brain injury, community
9.24 alternative care, community access for disability inclusion, and developmental disability
9.25 waiver plans; and
9.26 (7) employment support services as defined under the brain injury, community alternative
9.27 care, community access for disability inclusion, and developmental disability waiver plans.

9.28 Sec. 4. Minnesota Statutes 2016, section 245D.071, subdivision 5, is amended to read:

9.29 Subd. 5. **Service plan review and evaluation.** (a) The license holder must give the
9.30 person or the person's legal representative and case manager an opportunity to participate
9.31 in the ongoing review and development of the service plan and the methods used to support
10.1 the person and accomplish outcomes identified in subdivisions 3 and 4. At least once per
10.2 year, or within 30 days of a written request by the person, the person's legal representative,
10.3 or the case manager, the license holder, in coordination with the person's support team or
10.4 expanded support team, must meet with the person, the person's legal representative, and
10.5 the case manager, and participate in service plan review meetings following stated timelines
10.6 established in the person's coordinated service and support plan or coordinated service and
10.7 support plan addendum ~~or within 30 days of a written request by the person, the person's~~
10.8 ~~legal representative, or the case manager, at a minimum of once per year.~~ The purpose of
10.9 the service plan review is to determine whether changes are needed to the service plan based
10.10 on the assessment information, the license holder's evaluation of progress towards
10.11 accomplishing outcomes, or other information provided by the support team or expanded
10.12 support team.

10.13 (b) At least once per year, the license holder, in coordination with the person's support
10.14 team or expanded support team, must meet with the person, the person's legal representative,
10.15 and the case manager to discuss how technology might be used to meet the person's desired
10.16 outcomes. The coordinated service and support plan or support plan addendum must include
10.17 a summary of this discussion. The summary must include a statement regarding any decision
10.18 made related to the use of technology and a description of any further research that must
10.19 be completed before a decision regarding the use of technology can be made. Nothing in

9.16 (iii) residential services provided to more than four persons with developmental
9.17 disabilities in a supervised living facility, including ICFs/DD;
9.18 (4) day services, including:
9.19 (i) structured day services as defined under the brain injury waiver plan;
9.20 (ii) day training and habilitation services under sections 252.41 to 252.46, and as defined
9.21 under the developmental disability waiver plan; and
9.22 (iii) prevocational services as defined under the brain injury and community access for
9.23 disability inclusion waiver plans; and
9.24 (5) employment exploration services as defined under the brain injury, community
9.25 alternative care, community access for disability inclusion, and developmental disability
9.26 waiver plans;
9.27 (6) employment development services as defined under the brain injury, community
9.28 alternative care, community access for disability inclusion, and developmental disability
9.29 waiver plans; and
9.30 (7) employment support services as defined under the brain injury, community alternative
9.31 care, community access for disability inclusion, and developmental disability waiver plans.

10.1 Sec. 4. Minnesota Statutes 2016, section 245D.071, subdivision 5, is amended to read:

10.2 Subd. 5. **Service plan review and evaluation.** (a) The license holder must give the
10.3 person or the person's legal representative and case manager an opportunity to participate
10.4 in the ongoing review and development of the service plan and the methods used to support
10.5 the person and accomplish outcomes identified in subdivisions 3 and 4. At least once per
10.6 year, or within 30 days of a written request by the person, the person's legal representative,
10.7 or the case manager, the license holder, in coordination with the person's support team or
10.8 expanded support team, must meet with the person, the person's legal representative, and
10.9 the case manager, and participate in service plan review meetings following stated timelines
10.10 established in the person's coordinated service and support plan or coordinated service and
10.11 support plan addendum ~~or within 30 days of a written request by the person, the person's~~
10.12 ~~legal representative, or the case manager, at a minimum of once per year.~~ The purpose of
10.13 the service plan review is to determine whether changes are needed to the service plan based
10.14 on the assessment information, the license holder's evaluation of progress towards
10.15 accomplishing outcomes, or other information provided by the support team or expanded
10.16 support team.

10.17 (b) At least once per year, the license holder, in coordination with the person's support
10.18 team or expanded support team, must meet with the person, the person's legal representative,
10.19 and the case manager to discuss how technology might be used to meet the person's desired
10.20 outcomes. The coordinated service and support plan or support plan addendum must include
10.21 a summary of this discussion. The summary must include a statement regarding any decision
10.22 made related to the use of technology and a description of any further research that must
10.23 be completed before a decision regarding the use of technology can be made. Nothing in

10.20 this paragraph requires the coordinated service and support plan to include the use of
10.21 technology for the provision of services.

10.22 ~~(b)~~ (c) The license holder must summarize the person's status and progress toward
10.23 achieving the identified outcomes and make recommendations and identify the rationale
10.24 for changing, continuing, or discontinuing implementation of supports and methods identified
10.25 in subdivision 4 in a report available at the time of the progress review meeting. The report
10.26 must be sent at least five working days prior to the progress review meeting if requested by
10.27 the team in the coordinated service and support plan or coordinated service and support
10.28 plan addendum.

10.29 ~~(c)~~ (d) The license holder must send the coordinated service and support plan addendum
10.30 to the person, the person's legal representative, and the case manager by mail within ten
10.31 working days of the progress review meeting. Within ten working days of the mailing of
10.32 the coordinated service and support plan addendum, the license holder must obtain dated
10.33 signatures from the person or the person's legal representative and the case manager to
10.34 document approval of any changes to the coordinated service and support plan addendum.

11.1 ~~(d)~~ (e) If, within ten working days of submitting changes to the coordinated service and
11.2 support plan and coordinated service and support plan addendum, the person or the person's
11.3 legal representative or case manager has not signed and returned to the license holder the
11.4 coordinated service and support plan or coordinated service and support plan addendum or
11.5 has not proposed written modifications to the license holder's submission, the submission
11.6 is deemed approved and the coordinated service and support plan addendum becomes
11.7 effective and remains in effect until the legal representative or case manager submits a
11.8 written request to revise the coordinated service and support plan addendum.

11.9 Sec. 5. Minnesota Statutes 2016, section 245D.091, subdivision 2, is amended to read:

11.10 Subd. 2. ~~Behavior~~ **Positive support professional qualifications.** A ~~behavior~~ positive
11.11 support professional providing behavioral positive support services as identified in section
11.12 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the
11.13 following areas as required under the brain injury and community access for disability
11.14 inclusion, community alternative care, and developmental disability waiver plans or successor
11.15 plans:

11.16 (1) ethical considerations;
11.17 (2) functional assessment;
11.18 (3) functional analysis;
11.19 (4) measurement of behavior and interpretation of data;
11.20 (5) selecting intervention outcomes and strategies;
11.21 (6) behavior reduction and elimination strategies that promote least restrictive approved
11.22 alternatives;
11.23 (7) data collection;

10.24 this paragraph requires the coordinated service and support plan to include the use of
10.25 technology for the provision of services.

10.26 ~~(b)~~ (c) The license holder must summarize the person's status and progress toward
10.27 achieving the identified outcomes and make recommendations and identify the rationale
10.28 for changing, continuing, or discontinuing implementation of supports and methods identified
10.29 in subdivision 4 in a report available at the time of the progress review meeting. The report
10.30 must be sent at least five working days prior to the progress review meeting if requested by
10.31 the team in the coordinated service and support plan or coordinated service and support
10.32 plan addendum.

10.33 ~~(c)~~ (d) The license holder must send the coordinated service and support plan addendum
10.34 to the person, the person's legal representative, and the case manager by mail within ten
10.35 working days of the progress review meeting. Within ten working days of the mailing of
11.1 the coordinated service and support plan addendum, the license holder must obtain dated
11.2 signatures from the person or the person's legal representative and the case manager to
11.3 document approval of any changes to the coordinated service and support plan addendum.

11.4 ~~(d)~~ (e) If, within ten working days of submitting changes to the coordinated service and
11.5 support plan and coordinated service and support plan addendum, the person or the person's
11.6 legal representative or case manager has not signed and returned to the license holder the
11.7 coordinated service and support plan or coordinated service and support plan addendum or
11.8 has not proposed written modifications to the license holder's submission, the submission
11.9 is deemed approved and the coordinated service and support plan addendum becomes
11.10 effective and remains in effect until the legal representative or case manager submits a
11.11 written request to revise the coordinated service and support plan addendum.

11.12 Sec. 5. Minnesota Statutes 2016, section 245D.091, subdivision 2, is amended to read:

11.13 Subd. 2. ~~Behavior~~ **Positive support professional qualifications.** A ~~behavior~~ positive
11.14 support professional providing behavioral positive support services as identified in section
11.15 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the
11.16 following areas as required under the brain injury and community access for disability
11.17 inclusion, community alternative care, and developmental disability waiver plans or successor
11.18 plans:

11.19 (1) ethical considerations;
11.20 (2) functional assessment;
11.21 (3) functional analysis;
11.22 (4) measurement of behavior and interpretation of data;
11.23 (5) selecting intervention outcomes and strategies;
11.24 (6) behavior reduction and elimination strategies that promote least restrictive approved
11.25 alternatives;
11.26 (7) data collection;

11.24 (8) staff and caregiver training;
 11.25 (9) support plan monitoring;
 11.26 (10) co-occurring mental disorders or neurocognitive disorder;
 11.27 (11) demonstrated expertise with populations being served; and
 11.28 (12) must be a:
 11.29 (i) psychologist licensed under sections 148.88 to 148.98, who has stated to the Board
 11.30 of Psychology competencies in the above identified areas;
 12.1 (ii) clinical social worker licensed as an independent clinical social worker under chapter
 12.2 148D, or a person with a master's degree in social work from an accredited college or
 12.3 university, with at least 4,000 hours of post-master's supervised experience in the delivery
 12.4 of clinical services in the areas identified in clauses (1) to (11);
 12.5 (iii) physician licensed under chapter 147 and certified by the American Board of
 12.6 Psychiatry and Neurology or eligible for board certification in psychiatry with competencies
 12.7 in the areas identified in clauses (1) to (11);
 12.8 (iv) licensed professional clinical counselor licensed under sections 148B.29 to 148B.39
 12.9 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical
 12.10 services who has demonstrated competencies in the areas identified in clauses (1) to (11);
 12.11 (v) person with a master's degree from an accredited college or university in one of the
 12.12 behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised
 12.13 experience in the delivery of clinical services with demonstrated competencies in the areas
 12.14 identified in clauses (1) to (11); ~~or~~
 12.15 (vi) person with a master's degree or PhD in one of the behavioral sciences or related
 12.16 field with demonstrated expertise in positive support services, as determined by the person's
 12.17 case manager based on the person's needs as outlined in the person's community support
 12.18 plan from a supervisor who meets the qualifications in this subdivision; or
 12.19 (vii) registered nurse who is licensed under sections 148.171 to 148.285, and who is
 12.20 certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and
 12.21 mental health nursing by a national nurse certification organization, or who has a master's
 12.22 degree in nursing or one of the behavioral sciences or related fields from an accredited
 12.23 college or university or its equivalent, with at least 4,000 hours of post-master's supervised
 12.24 experience in the delivery of clinical services.

12.25 Sec. 6. Minnesota Statutes 2016, section 245D.091, subdivision 3, is amended to read:

12.26 Subd. 3. ~~Behavior~~ **Positive support analyst qualifications.** (a) A ~~behavior~~ positive
 12.27 support analyst providing behavioral positive support services as identified in section
 12.28 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the
 12.29 following areas as required under the brain injury and community access for disability
 12.30 inclusion, community alternative care, and developmental disability waiver plans or successor
 12.31 plans:

11.27 (8) staff and caregiver training;
 11.28 (9) support plan monitoring;
 11.29 (10) co-occurring mental disorders or neurocognitive disorder;
 11.30 (11) demonstrated expertise with populations being served; and
 11.31 (12) must be a:
 12.1 (i) psychologist licensed under sections 148.88 to 148.98, who has stated to the Board
 12.2 of Psychology competencies in the above identified areas;
 12.3 (ii) clinical social worker licensed as an independent clinical social worker under chapter
 12.4 148D, or a person with a master's degree in social work from an accredited college or
 12.5 university, with at least 4,000 hours of post-master's supervised experience in the delivery
 12.6 of clinical services in the areas identified in clauses (1) to (11);
 12.7 (iii) physician licensed under chapter 147 and certified by the American Board of
 12.8 Psychiatry and Neurology or eligible for board certification in psychiatry with competencies
 12.9 in the areas identified in clauses (1) to (11);
 12.10 (iv) licensed professional clinical counselor licensed under sections 148B.29 to 148B.39
 12.11 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical
 12.12 services who has demonstrated competencies in the areas identified in clauses (1) to (11);
 12.13 (v) person with a master's degree from an accredited college or university in one of the
 12.14 behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised
 12.15 experience in the delivery of clinical services with demonstrated competencies in the areas
 12.16 identified in clauses (1) to (11); ~~or~~
 12.17 (vi) person with a master's degree or PhD in one of the behavioral sciences or related
 12.18 fields with demonstrated expertise in positive support services; or
 12.19 (vii) registered nurse who is licensed under sections 148.171 to 148.285, and who is
 12.20 certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and
 12.21 mental health nursing by a national nurse certification organization, or who has a master's
 12.22 degree in nursing or one of the behavioral sciences or related fields from an accredited
 12.23 college or university or its equivalent, with at least 4,000 hours of post-master's supervised
 12.24 experience in the delivery of clinical services.

12.25 Sec. 6. Minnesota Statutes 2016, section 245D.091, subdivision 3, is amended to read:

12.26 Subd. 3. ~~Behavior~~ **Positive support analyst qualifications.** (a) A ~~behavior~~ positive
 12.27 support analyst providing behavioral positive support services as identified in section
 12.28 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the
 12.29 following areas as required under the brain injury and community access for disability
 12.30 inclusion, community alternative care, and developmental disability waiver plans or successor
 12.31 plans:

12.32 (1) have obtained a baccalaureate degree, master's degree, or PhD in a social services
 12.33 discipline; ~~or~~

13.1 (2) meet the qualifications of a mental health practitioner as defined in section 245.462,
 13.2 subdivision 17; or

13.3 (3) be a board certified behavior analyst or board certified assistant behavior analyst by
 13.4 the Behavior Analyst Certification Board, Incorporated.

13.5 (b) In addition, a ~~behavior~~ positive support analyst must:

13.6 (1) have four years of supervised experience ~~working with individuals who exhibit~~
 13.7 ~~challenging behaviors as well as co-occurring mental disorders or neurocognitive disorder~~
 13.8 ~~conducting functional behavior assessments and designing, implementing, and evaluating~~
 13.9 ~~effectiveness of positive practices behavior support strategies for people who exhibit~~
 13.10 ~~challenging behaviors as well as co-occurring mental disorders and neurocognitive disorder;~~

13.11 (2) have received ~~ten hours of instruction in functional assessment and functional analysis;~~
 13.12 ~~training prior to hire or within 90 calendar days of hire that includes:~~

13.13 (i) ten hours of instruction in functional assessment and functional analysis;

13.14 (ii) 20 hours of instruction in the understanding of the function of behavior;

13.15 (iii) ten hours of instruction on design of positive practices behavior support strategies;

13.16 (iv) 20 hours of instruction preparing written intervention strategies, designing data
 13.17 collection protocols, training other staff to implement positive practice strategies,
 13.18 summarizing and reporting program evaluation data, analyzing program evaluation data to
 13.19 identify design flaws in behavioral interventions or failures in implementation fidelity, and
 13.20 recommending enhancements based on evaluation data; and

13.21 (v) eight hours of instruction on principles of person-centered thinking;

13.22 ~~(3) have received 20 hours of instruction in the understanding of the function of behavior;~~

13.23 ~~(4) have received ten hours of instruction on design of positive practices behavior support~~
 13.24 ~~strategies;~~

13.25 ~~(5) have received 20 hours of instruction on the use of behavior reduction approved~~
 13.26 ~~strategies used only in combination with behavior positive practices strategies;~~

13.27 ~~(6)~~ (3) be determined by a ~~behavior~~ positive support professional to have the training
 13.28 and prerequisite skills required to provide positive practice strategies as well as behavior
 13.29 reduction approved and permitted intervention to the person who receives ~~behavioral~~ positive
 13.30 support; and

13.31 ~~(7)~~ (4) be under the direct supervision of a ~~behavior~~ positive support professional.

14.1 (c) Meeting the qualifications for a positive support professional under subdivision 2
 14.2 shall substitute for meeting the qualifications listed in paragraph (b).

12.32 (1) have obtained a baccalaureate degree, master's degree, or PhD in a social services
 12.33 discipline; ~~or~~

13.1 (2) meet the qualifications of a mental health practitioner as defined in section 245.462,
 13.2 subdivision 17; or

13.3 (3) be a board certified behavior analyst or board certified assistant behavior analyst by
 13.4 the Behavior Analyst Certification Board, Incorporated.

13.5 (b) In addition, a ~~behavior~~ positive support analyst must:

13.6 (1) have four years of supervised experience ~~working with individuals who exhibit~~
 13.7 ~~challenging behaviors as well as co-occurring mental disorders or neurocognitive disorder~~
 13.8 ~~conducting functional behavior assessments and designing, implementing, and evaluating~~
 13.9 ~~effectiveness of positive practices behavior support strategies for people who exhibit~~
 13.10 ~~challenging behaviors as well as co-occurring mental disorders and neurocognitive disorder;~~

13.11 (2) have received ~~ten hours of instruction in functional assessment and functional analysis;~~
 13.12 ~~training prior to hire or within 90 calendar days of hire that includes:~~

13.13 (i) ten hours of instruction in functional assessment and functional analysis;

13.14 (ii) 20 hours of instruction in the understanding of the function of behavior;

13.15 (iii) ten hours of instruction on design of positive practices behavior support strategies;

13.16 (iv) 20 hours of instruction preparing written intervention strategies, designing data
 13.17 collection protocols, training other staff to implement positive practice strategies,
 13.18 summarizing and reporting program evaluation data, analyzing program evaluation data to
 13.19 identify design flaws in behavioral interventions or failures in implementation fidelity, and
 13.20 recommending enhancements based on evaluation data; and

13.21 (v) eight hours of instruction on principles of person-centered thinking;

13.22 ~~(3) have received 20 hours of instruction in the understanding of the function of behavior;~~

13.23 ~~(4) have received ten hours of instruction on design of positive practices behavior support~~
 13.24 ~~strategies;~~

13.25 ~~(5) have received 20 hours of instruction on the use of behavior reduction approved~~
 13.26 ~~strategies used only in combination with behavior positive practices strategies;~~

13.27 ~~(6)~~ (3) be determined by a ~~behavior~~ positive support professional to have the training
 13.28 and prerequisite skills required to provide positive practice strategies as well as behavior
 13.29 reduction approved and permitted intervention to the person who receives ~~behavioral~~ positive
 13.30 support; and

13.31 ~~(7)~~ (4) be under the direct supervision of a ~~behavior~~ positive support professional.

14.1 (c) Meeting the qualifications for a positive support professional under subdivision 2
 14.2 shall substitute for meeting the qualifications listed in paragraph (b).

14.3 Sec. 7. Minnesota Statutes 2016, section 245D.091, subdivision 4, is amended to read:

14.4 Subd. 4. ~~Behavior~~ **Positive support specialist qualifications.** (a) A ~~behavior~~ positive

14.5 support specialist providing ~~behavioral~~ positive support services as identified in section

14.6 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the

14.7 following areas as required under the brain injury ~~and~~ community access for disability

14.8 inclusion, community alternative care, and developmental disability waiver plans or successor

14.9 plans:

14.10 (1) have an associate's degree in a social services discipline; or

14.11 (2) have two years of supervised experience working with individuals who exhibit

14.12 challenging behaviors as well as co-occurring mental disorders or neurocognitive disorder.

14.13 (b) In addition, a behavior specialist must:

14.14 (1) have received training prior to hire or within 90 calendar days of hire that includes:

14.15 (i) a minimum of four hours of training in functional assessment;

14.16 ~~(2) have received~~ (ii) 20 hours of instruction in the understanding of the function of

14.17 behavior;

14.18 ~~(3) have received~~ (iii) ten hours of instruction on design of positive practices behavioral

14.19 support strategies; and

14.20 (iv) eight hours of instruction on principles of person-centered thinking;

14.21 ~~(4)~~ (2) be determined by a ~~behavior~~ positive support professional to have the training

14.22 and prerequisite skills required to provide positive practices strategies as well as behavior

14.23 reduction approved intervention to the person who receives ~~behavioral~~ positive support;

14.24 and

14.25 ~~(5)~~ (3) be under the direct supervision of a ~~behavior~~ positive support professional.

14.26 (c) Meeting the qualifications for a positive support professional under subdivision 2

14.27 shall substitute for meeting the qualifications listed in paragraphs (a) and (b).

14.3 Sec. 7. Minnesota Statutes 2016, section 245D.091, subdivision 4, is amended to read:

14.4 Subd. 4. ~~Behavior~~ **Positive support specialist qualifications.** (a) A ~~behavior~~ positive

14.5 support specialist providing ~~behavioral~~ positive support services as identified in section

14.6 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the

14.7 following areas as required under the brain injury ~~and~~ community access for disability

14.8 inclusion, community alternative care, and developmental disability waiver plans or successor

14.9 plans:

14.10 (1) have an associate's degree in a social services discipline; or

14.11 (2) have two years of supervised experience working with individuals who exhibit

14.12 challenging behaviors as well as co-occurring mental disorders or neurocognitive disorder.

14.13 (b) In addition, a behavior specialist must:

14.14 (1) have received training prior to hire or within 90 calendar days of hire that includes:

14.15 (i) a minimum of four hours of training in functional assessment;

14.16 ~~(2) have received~~ (ii) 20 hours of instruction in the understanding of the function of

14.17 behavior;

14.18 ~~(3) have received~~ (iii) ten hours of instruction on design of positive practices behavioral

14.19 support strategies; and

14.20 (iv) eight hours of instruction on principles of person-centered thinking;

14.21 ~~(4)~~ (2) be determined by a ~~behavior~~ positive support professional to have the training

14.22 and prerequisite skills required to provide positive practices strategies as well as behavior

14.23 reduction approved intervention to the person who receives ~~behavioral~~ positive support;

14.24 and

14.25 ~~(5)~~ (3) be under the direct supervision of a ~~behavior~~ positive support professional.

14.26 (c) Meeting the qualifications for a positive support professional under subdivision 2

14.27 shall substitute for meeting the qualifications listed in paragraphs (a) and (b).

14.28 Sec. 8. Minnesota Statutes 2016, section 256B.0659, subdivision 3a, is amended to read:

14.29 Subd. 3a. **Assessment; defined.** (a) "Assessment" means a review and evaluation of a

14.30 recipient's need for personal care assistance services conducted in person. Assessments for

15.1 personal care assistance services shall be conducted by the county public health nurse or a

15.2 certified public health nurse under contract with the county except when a long-term care

15.3 consultation assessment is being conducted for the purposes of determining a person's

15.4 eligibility for home and community-based waiver services including personal care assistance

15.5 services according to section 256B.0911. During the transition to MnCHOICES, a certified

15.6 assessor may complete the assessment defined in this subdivision. An in-person assessment

15.7 must include: documentation of health status, determination of need, evaluation of service

15.8 effectiveness, identification of appropriate services, service plan development or modification,

15.9 coordination of services, referrals and follow-up to appropriate payers and community

15.10 resources, completion of required reports, recommendation of service authorization, and

15.11 consumer education. Once the need for personal care assistance services is determined under
15.12 this section, the county public health nurse or certified public health nurse under contract
15.13 with the county is responsible for communicating this recommendation to the commissioner
15.14 and the recipient. An in-person assessment must occur at least annually or when there is a
15.15 significant change in the recipient's condition or when there is a change in the need for
15.16 personal care assistance services. A service update may substitute for the annual face-to-face
15.17 assessment when there is not a significant change in recipient condition or a change in the
15.18 need for personal care assistance service. A service update may be completed by telephone,
15.19 used when there is no need for an increase in personal care assistance services, and used
15.20 for two consecutive assessments if followed by a face-to-face assessment. A service update
15.21 must be completed on a form approved by the commissioner. A service update or review
15.22 for temporary increase includes a review of initial baseline data, evaluation of service
15.23 effectiveness, redetermination of service need, modification of service plan and appropriate
15.24 referrals, update of initial forms, obtaining service authorization, and on going consumer
15.25 education. Assessments or reassessments must be completed on forms provided by the
15.26 commissioner within 30 days of a request for home care services by a recipient or responsible
15.27 party.

15.28 (b) This subdivision expires when notification is given by the commissioner as described
15.29 in section 256B.0911, subdivision 3a.

15.30 Sec. 9. Minnesota Statutes 2017 Supplement, section 256B.0911, subdivision 1a, is
15.31 amended to read:

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

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

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

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

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

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

16.7 (5) face-to-face long-term care consultation assessments, which may be completed in a
16.8 hospital, nursing facility, intermediate care facility for persons with developmental disabilities
16.9 (ICF/DDs), regional treatment centers, or the person's current or planned residence;

16.10 (6) determination of home and community-based waiver and other service eligibility as
16.11 required under sections 256B.0913, 256B.0915, and 256B.49, including level of care
16.12 determination for individuals who need an institutional level of care as determined under
16.13 subdivision 4e, based on assessment and community support plan development, appropriate
16.14 referrals to obtain necessary diagnostic information, and including an eligibility determination
16.15 for consumer-directed community supports;

- 16.16 (7) providing recommendations for institutional placement when there are no
16.17 cost-effective community services available;
- 16.18 (8) providing access to assistance to transition people back to community settings after
16.19 institutional admission; and
- 16.20 (9) providing information about competitive employment, with or without supports, for
16.21 school-age youth and working-age adults and referrals to the Disability Linkage Line and
16.22 Disability Benefits 101 to ensure that an informed choice about competitive employment
16.23 can be made. For the purposes of this subdivision, "competitive employment" means work
16.24 in the competitive labor market that is performed on a full-time or part-time basis in an
16.25 integrated setting, and for which an individual is compensated at or above the minimum
16.26 wage, but not less than the customary wage and level of benefits paid by the employer for
16.27 the same or similar work performed by individuals without disabilities.
- 16.28 (b) Upon statewide implementation of lead agency requirements in subdivisions 2b, 2c,
16.29 and 3a, "long-term care consultation services" also means:
- 16.30 (1) service eligibility determination for state plan ~~home care~~ services identified in:
16.31 (i) section 256B.0625, subdivisions 7, 19a; and 19c;
16.32 (ii) consumer support grants under section 256.476; or
17.1 (iii) section 256B.85;
- 17.2 (2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,
17.3 determination of eligibility for case management services available under sections 256B.0621,
17.4 subdivision 2, ~~paragraph~~ clause (4), and 256B.0924 and Minnesota Rules, ~~part 9525.0016;~~
17.5 (3) determination of institutional level of care, home and community-based service
17.6 waiver, and other service eligibility as required under section 256B.092, ~~determination of~~
17.7 ~~eligibility for family support grants under section 252.32;~~ semi-independent living services
17.8 under section 252.275, and day training and habilitation services under section 256B.092;
17.9 ~~and~~
- 17.10 (4) obtaining necessary diagnostic information to determine eligibility under clauses (2)
17.11 and (3); and
- 17.12 (5) notwithstanding Minnesota Rules, parts 9525.0004 to 9525.0024, initial eligibility
17.13 determination for case management services available under Minnesota Rules, part
17.14 9525.0016.
- 17.15 (c) "Long-term care options counseling" means the services provided by the linkage
17.16 lines as mandated by sections 256.01, subdivision 24, and 256.975, subdivision 7, and also
17.17 includes telephone assistance and follow up once a long-term care consultation assessment
17.18 has been completed.
- 17.19 (d) "Minnesota health care programs" means the medical assistance program under this
17.20 chapter and the alternative care program under section 256B.0913.

17.21 (e) "Lead agencies" means counties administering or tribes and health plans under
 17.22 contract with the commissioner to administer long-term care consultation assessment and
 17.23 support planning services.

17.24 (f) "Person-centered planning" is a process that includes the active participation of a
 17.25 person in the planning of the person's services, including in making meaningful and informed
 17.26 choices about the person's own goals, talents, and objectives, as well as making meaningful
 17.27 and informed choices about the services the person receives. For the purposes of this section,
 17.28 "informed choice" means a voluntary choice of services by a person from all available
 17.29 service options based on accurate and complete information concerning all available service
 17.30 options and concerning the person's own preferences, abilities, goals, and objectives. In
 17.31 order for a person to make an informed choice, all available options must be developed and
 17.32 presented to the person to empower the person to make decisions.

18.1 Sec. 10. Minnesota Statutes 2017 Supplement, section 256B.0911, subdivision 3a, is
 18.2 amended to read:

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

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

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

18.20 (d) The assessment must be conducted in a face-to-face conversational interview with
 18.21 the person being assessed ~~and~~. The person's legal representative must provide input during
 18.22 the assessment process and may do so remotely if requested. At the request of the person,
 18.23 other individuals may participate in the assessment to provide information on the needs,
 18.24 strengths, and preferences of the person necessary to develop a community support plan
 18.25 that ensures the person's health and safety. Except for legal representatives or family members
 18.26 invited by the person, persons participating in the assessment may not be a provider of
 18.27 service or have any financial interest in the provision of services. For persons who are to
 18.28 be assessed for elderly waiver customized living or adult day services under section
 18.29 256B.0915, with the permission of the person being assessed or the person's designated or

18.30 legal representative, the client's current or proposed provider of services may submit a copy
 18.31 of the provider's nursing assessment or written report outlining its recommendations regarding
 18.32 the client's care needs. The person conducting the assessment must notify the provider of
 18.33 the date by which this information is to be submitted. This information shall be provided
 18.34 to the person conducting the assessment prior to the assessment. For a person who is to be
 18.35 assessed for waiver services under section 256B.092 or 256B.49, with the permission of
 19.1 the person being assessed or the person's designated legal representative, the person's current
 19.2 provider of services may submit a written report outlining recommendations regarding the
 19.3 person's care needs prepared by a direct service employee with at least 20 hours of service
 19.4 to that client. The person conducting the assessment or reassessment must notify the provider
 19.5 of the date by which this information is to be submitted. This information shall be provided
 19.6 to the person conducting the assessment and the person or the person's legal representative,
 19.7 and must be considered prior to the finalization of the assessment or reassessment.

19.8 (e) The person or the person's legal representative must be provided with a written
 19.9 community support plan within ~~40 calendar days of the assessment visit~~ the timelines
 19.10 established by the commissioner, regardless of whether the individual is eligible for
 19.11 Minnesota health care programs. The timeline for completing the community support plan
 19.12 and any required coordinated service and support plan must not exceed 56 calendar days
 19.13 from the assessment visit.

19.14 (f) For a person being assessed for elderly waiver services under section 256B.0915, a
 19.15 provider who submitted information under paragraph (d) shall receive the final written
 19.16 community support plan when available and the Residential Services Workbook.

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

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

19.19 (2) the individual's options and choices to meet identified needs, including all available
 19.20 options for case management services and providers, including service provided in a
 19.21 non-disability-specific setting;

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

19.24 (4) referral information; and

19.25 (5) informal caregiver supports, if applicable.

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

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

- 20.1 (i) The person has the right to make the final decision between institutional placement
 20.2 and community placement after the recommendations have been provided, except as provided
 20.3 in section 256.975, subdivision 7a, paragraph (d).
- 20.4 (j) The lead agency must give the person receiving assessment or support planning, or
 20.5 the person's legal representative, materials, and forms supplied by the commissioner
 20.6 containing the following information:
- 20.7 (1) written recommendations for community-based services and consumer-directed
 20.8 options;
- 20.9 (2) documentation that the most cost-effective alternatives available were offered to the
 20.10 individual. For purposes of this clause, "cost-effective" means community services and
 20.11 living arrangements that cost the same as or less than institutional care. For an individual
 20.12 found to meet eligibility criteria for home and community-based service programs under
 20.13 section 256B.0915 or 256B.49, "cost-effectiveness" has the meaning found in the federally
 20.14 approved waiver plan for each program;
- 20.15 (3) the need for and purpose of preadmission screening conducted by long-term care
 20.16 options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects
 20.17 nursing facility placement. If the individual selects nursing facility placement, the lead
 20.18 agency shall forward information needed to complete the level of care determinations and
 20.19 screening for developmental disability and mental illness collected during the assessment
 20.20 to the long-term care options counselor using forms provided by the commissioner;
- 20.21 (4) the role of long-term care consultation assessment and support planning in eligibility
 20.22 determination for waiver and alternative care programs, and state plan home care, case
 20.23 management, and other services as defined in subdivision 1a, paragraphs (a), clause (6),
 20.24 and (b);
- 20.25 (5) information about Minnesota health care programs;
- 20.26 (6) the person's freedom to accept or reject the recommendations of the team;
- 20.27 (7) the person's right to confidentiality under the Minnesota Government Data Practices
 20.28 Act, chapter 13;
- 20.29 (8) the certified assessor's decision regarding the person's need for institutional level of
 20.30 care as determined under criteria established in subdivision 4c and the certified assessor's
 20.31 decision regarding eligibility for all services and programs as defined in subdivision 1a,
 20.32 paragraphs (a), clause (6), and (b); and
- 21.1 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
 21.2 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
 21.3 (8), and (b), and incorporating the decision regarding the need for institutional level of care
 21.4 or the lead agency's final decisions regarding public programs eligibility according to section
 21.5 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right
 21.6 to the person and must visually point out where in the document the right to appeal is stated.

- 21.7 (k) Face-to-face assessment completed as part of eligibility determination for the
 21.8 alternative care, elderly waiver, developmental disabilities, community access for disability
 21.9 inclusion, community alternative care, and brain injury waiver programs under sections
 21.10 256B.0913, 256B.0915, 256B.092, and 256B.49 is valid to establish service eligibility for
 21.11 no more than 60 calendar days after the date of assessment.
- 21.12 (l) The effective eligibility start date for programs in paragraph (k) can never be prior
 21.13 to the date of assessment. If an assessment was completed more than 60 days before the
 21.14 effective waiver or alternative care program eligibility start date, assessment and support
 21.15 plan information must be updated and documented in the department's Medicaid Management
 21.16 Information System (MMIS). Notwithstanding retroactive medical assistance coverage of
 21.17 state plan services, the effective date of eligibility for programs included in paragraph (k)
 21.18 cannot be prior to the date the most recent updated assessment is completed.
- 21.19 (m) If an eligibility update is completed within 90 days of the previous face-to-face
 21.20 assessment and documented in the department's Medicaid Management Information System
 21.21 (MMIS), the effective date of eligibility for programs included in paragraph (k) is the date
 21.22 of the previous face-to-face assessment when all other eligibility requirements are met.
- 21.23 (n) At the time of reassessment, the certified assessor shall assess each person receiving
 21.24 waiver services currently residing in a community residential setting, or licensed adult foster
 21.25 care home that is not the primary residence of the license holder, or in which the license
 21.26 holder is not the primary caregiver, to determine if that person would prefer to be served in
 21.27 a community-living setting as defined in section 256B.49, subdivision 23. The certified
 21.28 assessor shall offer the person, through a person-centered planning process, the option to
 21.29 receive alternative housing and service options.
- 21.30 Sec. 11. Minnesota Statutes 2017 Supplement, section 256B.0911, subdivision 3f, is
 21.31 amended to read:
- 21.32 Subd. 3f. **Long-term care reassessments and community support plan updates.** (a)
 21.33 Prior to a face-to-face reassessment, the certified assessor must review the person's most
 21.34 recent assessment. Reassessments must be tailored using the professional judgment of the
 22.1 assessor to the person's known needs, strengths, preferences, and circumstances.
 22.2 Reassessments provide information to support the person's informed choice and opportunities
 22.3 to express choice regarding activities that contribute to quality of life, as well as information
 22.4 and opportunity to identify goals related to desired employment, community activities, and
 22.5 preferred living environment. Reassessments ~~allow for~~ require a review of the most recent
 22.6 assessment, review of the current coordinated service and support plan's effectiveness,
 22.7 monitoring of services, and the development of an updated person-centered community
 22.8 support plan. Reassessments verify continued eligibility or offer alternatives as warranted
 22.9 and provide an opportunity for quality assurance of service delivery. Face-to-face assessments
 22.10 reassessments must be conducted annually or as required by federal and state laws and rules.
 22.11 For reassessments, the certified assessor and the individual responsible for developing the
 22.12 coordinated service and support plan must ensure the continuity of care for the person

- 22.13 receiving services and complete the updated community support plan and the updated
22.14 coordinated service and support plan within the timelines established by the commissioner.
- 22.15 (b) The commissioner shall develop mechanisms for providers and case managers to
22.16 share information with the assessor to facilitate a reassessment and support planning process
22.17 tailored to the person's current needs and preferences.
- 22.18 Sec. 12. Minnesota Statutes 2017 Supplement, section 256B.0911, subdivision 5, is
22.19 amended to read:
- 22.20 Subd. 5. **Administrative activity.** (a) The commissioner shall streamline the processes,
22.21 including timelines for when assessments need to be completed, required to provide the
22.22 services in this section and shall implement integrated solutions to automate the business
22.23 processes to the extent necessary for community support plan approval, reimbursement,
22.24 program planning, evaluation, and policy development.
- 22.25 (b) The commissioner of human services shall work with lead agencies responsible for
22.26 conducting long-term consultation services to modify the MnCHOICES application and
22.27 assessment policies to create efficiencies while ensuring federal compliance with medical
22.28 assistance and long-term services and supports eligibility criteria.
- 22.29 (c) The commissioner shall work with lead agencies responsible for conducting long-term
22.30 consultation services to develop a set of measurable benchmarks sufficient to demonstrate
22.31 quarterly improvement in the average time per assessment and other mutually agreed upon
22.32 measures of increasing efficiency. The commissioner shall collect data on these benchmarks
22.33 and provide to the lead agencies and the chairs and ranking minority members of the
22.34 legislative committees with jurisdiction over human services an annual trend analysis of
23.1 the data in order to demonstrate the commissioner's compliance with the requirements of
23.2 this subdivision.
- 23.3 Sec. 13. Minnesota Statutes 2016, section 256B.0915, subdivision 6, is amended to read:
- 23.4 Subd. 6. **Implementation of coordinated service and support plan.** (a) Each elderly
23.5 waiver client shall be provided a copy of a written coordinated service and support plan
23.6 ~~which~~ that:
- 23.7 (1) is developed with and signed by the recipient within ~~ten working days after the case~~
23.8 ~~manager receives the assessment information and written community support plan as~~
23.9 ~~described in section 256B.0911, subdivision 3a, from the certified assessor the timelines~~
23.10 established by the commissioner. The timeline for completing the community support plan
23.11 under section 256B.0911, subdivision 3a, and the coordinated service and support plan must
23.12 not exceed 56 calendar days from the assessment visit;
- 23.13 (2) includes the person's need for service and identification of service needs that will be
23.14 or that are met by the person's relatives, friends, and others, as well as community services
23.15 used by the general public;
- 23.16 (3) reasonably ensures the health and welfare of the recipient;

- 23.17 (4) identifies the person's preferences for services as stated by the person or the person's
 23.18 legal guardian or conservator;
- 23.19 (5) reflects the person's informed choice between institutional and community-based
 23.20 services, as well as choice of services, supports, and providers, including available case
 23.21 manager providers;
- 23.22 (6) identifies long-range and short-range goals for the person;
- 23.23 (7) identifies specific services and the amount, frequency, duration, and cost of the
 23.24 services to be provided to the person based on assessed needs, preferences, and available
 23.25 resources;
- 23.26 (8) includes information about the right to appeal decisions under section 256.045; and
- 23.27 (9) includes the authorized annual and estimated monthly amounts for the services.
- 23.28 (b) In developing the coordinated service and support plan, the case manager should
 23.29 also include the use of volunteers, religious organizations, social clubs, and civic and service
 23.30 organizations to support the individual in the community. The lead agency must be held
 23.31 harmless for damages or injuries sustained through the use of volunteers and agencies under
 23.32 this paragraph, including workers' compensation liability.
- 24.1 Sec. 14. Minnesota Statutes 2016, section 256B.092, subdivision 1b, is amended to read:
- 24.2 Subd. 1b. **Coordinated service and support plan.** (a) Each recipient of home and
 24.3 community-based waived services shall be provided a copy of the written coordinated
 24.4 service and support plan ~~which that~~:
- 24.5 (1) is developed with and signed by the recipient within ~~ten working days after the case~~
 24.6 ~~manager receives the assessment information and written community support plan as~~
 24.7 ~~described in section 256B.0911, subdivision 3a, from the certified assessor~~ the timelines
 24.8 established by the commissioner. The timeline for completing the community support plan
 24.9 under section 256B.0911, subdivision 3a, and the coordinated service and support plan must
 24.10 not exceed 56 calendar days from the assessment visit;
- 24.11 (2) includes the person's need for service, including identification of service needs that
 24.12 will be or that are met by the person's relatives, friends, and others, as well as community
 24.13 services used by the general public;
- 24.14 (3) reasonably ensures the health and welfare of the recipient;
- 24.15 (4) identifies the person's preferences for services as stated by the person, the person's
 24.16 legal guardian or conservator, or the parent if the person is a minor, including the person's
 24.17 choices made on self-directed options and on services and supports to achieve employment
 24.18 goals;
- 24.19 (5) provides for an informed choice, as defined in section 256B.77, subdivision 2,
 24.20 paragraph (o), of service and support providers, and identifies all available options for case
 24.21 management services and providers;

- 24.22 (6) identifies long-range and short-range goals for the person;
- 24.23 (7) identifies specific services and the amount and frequency of the services to be provided
- 24.24 to the person based on assessed needs, preferences, and available resources. The coordinated
- 24.25 service and support plan shall also specify other services the person needs that are not
- 24.26 available;
- 24.27 (8) identifies the need for an individual program plan to be developed by the provider
- 24.28 according to the respective state and federal licensing and certification standards, and
- 24.29 additional assessments to be completed or arranged by the provider after service initiation;
- 24.30 (9) identifies provider responsibilities to implement and make recommendations for
- 24.31 modification to the coordinated service and support plan;
- 25.1 (10) includes notice of the right to request a conciliation conference or a hearing under
- 25.2 section 256.045;
- 25.3 (11) is agreed upon and signed by the person, the person's legal guardian or conservator,
- 25.4 or the parent if the person is a minor, and the authorized county representative;
- 25.5 (12) is reviewed by a health professional if the person has overriding medical needs that
- 25.6 impact the delivery of services; and
- 25.7 (13) includes the authorized annual and monthly amounts for the services.
- 25.8 (b) In developing the coordinated service and support plan, the case manager is
- 25.9 encouraged to include the use of volunteers, religious organizations, social clubs, and civic
- 25.10 and service organizations to support the individual in the community. The lead agency must
- 25.11 be held harmless for damages or injuries sustained through the use of volunteers and agencies
- 25.12 under this paragraph, including workers' compensation liability.
- 25.13 (c) Approved, written, and signed changes to a consumer's services that meet the criteria
- 25.14 in this subdivision shall be an addendum to that consumer's individual service plan.
- 25.15 Sec. 15. Minnesota Statutes 2016, section 256B.092, subdivision 1g, is amended to read:
- 25.16 Subd. 1g. **Conditions not requiring development of coordinated service and support**
- 25.17 **plan.** (a) Unless otherwise required by federal law, the county agency is not required to
- 25.18 complete a coordinated service and support plan as defined in subdivision 1b for:
- 25.19 (1) persons whose families are requesting respite care for their family member who
- 25.20 resides with them, or whose families are requesting a family support grant and are not
- 25.21 requesting purchase or arrangement of habilitative services; and
- 25.22 (2) persons with developmental disabilities, living independently without authorized
- 25.23 services or receiving funding for services at a rehabilitation facility as defined in section
- 25.24 268A.01, subdivision 6, and not in need of or requesting additional services.
- 25.25 (b) Unless otherwise required by federal law, the county agency is not required to conduct
- 25.26 or arrange for an annual needs reassessment by a certified assessor. The case manager who
- 25.27 works on behalf of the person to identify their needs and to minimize the impact of the

25.28 disability on the person's life must develop a person-centered service plan based on the
 25.29 person's assessed needs and preferences. The person-centered service plan must be reviewed
 25.30 annually. This paragraph applies to persons with developmental disabilities who are receiving
 25.31 case management services under Minnesota Rules, part 9525.0036, and who make an
 25.32 informed choice to decline an assessment under section 256B.0911.

26.1 Sec. 16. Minnesota Statutes 2017 Supplement, section 256B.49, subdivision 13, is amended
 26.2 to read:

26.3 Subd. 13. **Case management.** (a) Each recipient of a home and community-based waiver
 26.4 shall be provided case management services by qualified vendors as described in the federally
 26.5 approved waiver application. The case management service activities provided must include:

26.6 (1) finalizing the written coordinated service and support plan within ~~ten working days~~
 26.7 ~~after the case manager receives the plan from the certified assessor~~ the timelines established
 26.8 by the commissioner. The timeline for completing the community support plan under section
 26.9 256B.0911, subdivision 3a, and the coordinated service and support plan must not exceed
 26.10 56 calendar days from the assessment visit;

26.11 (2) informing the recipient or the recipient's legal guardian or conservator of service
 26.12 options;

26.13 (3) assisting the recipient in the identification of potential service providers and available
 26.14 options for case management service and providers, including services provided in a
 26.15 non-disability-specific setting;

26.16 (4) assisting the recipient to access services and assisting with appeals under section
 26.17 256.045; and

26.18 (5) coordinating, evaluating, and monitoring of the services identified in the service
 26.19 plan.

26.20 (b) The case manager may delegate certain aspects of the case management service
 26.21 activities to another individual provided there is oversight by the case manager. The case
 26.22 manager may not delegate those aspects which require professional judgment including:

26.23 (1) finalizing the coordinated service and support plan;

26.24 (2) ongoing assessment and monitoring of the person's needs and adequacy of the
 26.25 approved coordinated service and support plan; and

26.26 (3) adjustments to the coordinated service and support plan.

26.27 (c) Case management services must be provided by a public or private agency that is
 26.28 enrolled as a medical assistance provider determined by the commissioner to meet all of
 26.29 the requirements in the approved federal waiver plans. Case management services must not
 26.30 be provided to a recipient by a private agency that has any financial interest in the provision
 26.31 of any other services included in the recipient's coordinated service and support plan. For
 27.1 purposes of this section, "private agency" means any agency that is not identified as a lead
 27.2 agency under section 256B.0911, subdivision 1a, paragraph (e).

15.1 Sec. 8. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 3, is amended
15.2 to read:

15.3 Subd. 3. **Applicable services.** Applicable services are those authorized under the state's
15.4 home and community-based services waivers under sections 256B.092 and 256B.49,
15.5 including the following, as defined in the federally approved home and community-based
15.6 services plan:

15.7 (1) 24-hour customized living;
15.8 (2) adult day care;
15.9 (3) adult day care bath;
15.10 ~~(4) behavioral programming;~~
15.11 ~~(5)~~ (4) companion services;
15.12 ~~(6)~~ (5) customized living;
15.13 ~~(7)~~ (6) day training and habilitation;
15.14 (7) employment development services;
15.15 (8) employment exploration services;
15.16 (9) employment support services;
15.17 ~~(8)~~ (10) housing access coordination;
15.18 ~~(9)~~ (11) independent living skills;
15.19 (12) independent living skills specialist services;
15.20 (13) individualized home supports;
15.21 ~~(10)~~ (14) in-home family support;

27.3 (d) For persons who need a positive support transition plan as required in chapter 245D,
27.4 the case manager shall participate in the development and ongoing evaluation of the plan
27.5 with the expanded support team. At least quarterly, the case manager, in consultation with
27.6 the expanded support team, shall evaluate the effectiveness of the plan based on progress
27.7 evaluation data submitted by the licensed provider to the case manager. The evaluation must
27.8 identify whether the plan has been developed and implemented in a manner to achieve the
27.9 following within the required timelines:

27.10 (1) phasing out the use of prohibited procedures;
27.11 (2) acquisition of skills needed to eliminate the prohibited procedures within the plan's
27.12 timeline; and
27.13 (3) accomplishment of identified outcomes.

27.14 If adequate progress is not being made, the case manager shall consult with the person's
27.15 expanded support team to identify needed modifications and whether additional professional
27.16 support is required to provide consultation.

27.17 Sec. 17. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 3, is
27.18 amended to read:

27.19 Subd. 3. **Applicable services.** Applicable services are those authorized under the state's
27.20 home and community-based services waivers under sections 256B.092 and 256B.49,
27.21 including the following, as defined in the federally approved home and community-based
27.22 services plan:

27.23 (1) 24-hour customized living;
27.24 (2) adult day care;
27.25 (3) adult day care bath;
27.26 ~~(4) behavioral programming;~~
27.27 ~~(5)~~ (4) companion services;
27.28 ~~(6)~~ (5) customized living;
27.29 ~~(7)~~ (6) day training and habilitation;
27.30 (7) employment development services;
28.1 (8) employment exploration services;
28.2 (9) employment support services;
28.3 ~~(8)~~ (10) housing access coordination;
28.4 ~~(9)~~ (11) independent living skills;
28.5 (12) independent living skills specialist services;
28.6 (13) individualized home supports;
28.7 ~~(10)~~ (14) in-home family support;

15.22 ~~(11)~~ (15) night supervision;
15.23 ~~(12)~~ (16) personal support;
15.24 (17) positive support service;
15.25 ~~(13)~~ (18) prevocational services;
15.26 ~~(14)~~ (19) residential care services;
15.27 ~~(15)~~ (20) residential support services;
15.28 ~~(16)~~ (21) respite services;
16.1 ~~(17)~~ (22) structured day services;
16.2 ~~(18)~~ (23) supported employment services;
16.3 ~~(19)~~ (24) supported living services;
16.4 ~~(20)~~ (25) transportation services;
16.5 ~~(21)~~ individualized home supports;
16.6 ~~(22)~~ independent living skills specialist services;
16.7 ~~(23)~~ employment exploration services;
16.8 ~~(24)~~ employment development services;
16.9 ~~(25)~~ employment support services; and
16.10 (26) other services as approved by the federal government in the state home and
16.11 community-based services plan.

28.8 ~~(11)~~ (15) night supervision;
28.9 ~~(12)~~ (16) personal support;
28.10 (17) positive support service;
28.11 ~~(13)~~ (18) prevocational services;
28.12 ~~(14)~~ (19) residential care services;
28.13 ~~(15)~~ (20) residential support services;
28.14 ~~(16)~~ (21) respite services;
28.15 ~~(17)~~ (22) structured day services;
28.16 ~~(18)~~ (23) supported employment services;
28.17 ~~(19)~~ (24) supported living services;
28.18 ~~(20)~~ (25) transportation services;
28.19 ~~(21)~~ individualized home supports;
28.20 ~~(22)~~ independent living skills specialist services;
28.21 ~~(23)~~ employment exploration services;
28.22 ~~(24)~~ employment development services;
28.23 ~~(25)~~ employment support services; and
28.24 (26) other services as approved by the federal government in the state home and
28.25 community-based services plan.

29.1 Sec. 18. Minnesota Statutes 2017 Supplement, section 2561.03, subdivision 8, is amended
29.2 to read:

29.3 Subd. 8. **Supplementary services.** "Supplementary services" means housing support
29.4 services provided to individuals in addition to room and board including, but not limited
29.5 to, oversight and up to 24-hour supervision, medication reminders, assistance with
29.6 transportation, arranging for meetings and appointments, and arranging for medical and
29.7 social services. Providers must comply with section 2561.04, subdivision 2h.

29.8 Sec. 19. Minnesota Statutes 2017 Supplement, section 2561.04, subdivision 2b, is amended
29.9 to read:

29.10 Subd. 2b. **Housing support agreements.** (a) Agreements between agencies and providers
29.11 of housing support must be in writing on a form developed and approved by the commissioner
29.12 and must specify the name and address under which the establishment subject to the
29.13 agreement does business and under which the establishment, or service provider, if different
29.14 from the group residential housing establishment, is licensed by the Department of Health
29.15 or the Department of Human Services; the specific license or registration from the
29.16 Department of Health or the Department of Human Services held by the provider and the
29.17 number of beds subject to that license; the address of the location or locations at which

29.18 group residential housing is provided under this agreement; the per diem and monthly rates
29.19 that are to be paid from housing support funds for each eligible resident at each location;
29.20 the number of beds at each location which are subject to the agreement; whether the license
29.21 holder is a not-for-profit corporation under section 501(c)(3) of the Internal Revenue Code;
29.22 and a statement that the agreement is subject to the provisions of sections 256I.01 to 256I.06
29.23 and subject to any changes to those sections.

29.24 (b) Providers are required to verify the following minimum requirements in the
29.25 agreement:

29.26 (1) current license or registration, including authorization if managing or monitoring
29.27 medications;

29.28 (2) all staff who have direct contact with recipients meet the staff qualifications;

29.29 (3) the provision of housing support;

29.30 (4) the provision of supplementary services, if applicable;

29.31 (5) reports of adverse events, including recipient death or serious injury; ~~and~~

29.32 (6) submission of residency requirements that could result in recipient eviction; ~~and~~

30.1 (7) confirmation that the provider will not limit or restrict the number of hours an
30.2 applicant or recipient chooses to be employed, as specified in subdivision 5.

30.3 (c) Agreements may be terminated with or without cause by the commissioner, the
30.4 agency, or the provider with two calendar months prior notice. The commissioner may
30.5 immediately terminate an agreement under subdivision 2d.

30.6 Sec. 20. Minnesota Statutes 2016, section 256I.04, is amended by adding a subdivision
30.7 to read:

30.8 Subd. 2h. **Required supplementary services.** Providers of supplementary services shall
30.9 ensure that recipients have, at a minimum, assistance with services as identified in the
30.10 recipient's professional statement of need under section 256I.03, subdivision 12. Providers
30.11 of supplementary services shall maintain case notes with the date and description of services
30.12 provided to individual recipients.

30.13 Sec. 21. Minnesota Statutes 2016, section 256I.04, is amended by adding a subdivision
30.14 to read:

30.15 Subd. 5. **Employment.** A provider is prohibited from limiting or restricting the number
30.16 of hours an applicant or recipient is employed.

30.17 Sec. 22. **DIRECTION TO COMMISSIONER; BI AND CADI WAIVER**
30.18 **CUSTOMIZED LIVING SERVICES PROVIDER LOCATED IN HENNEPIN**
30.19 **COUNTY.**

30.20 (a) The commissioner of human services shall allow a housing with services establishment
30.21 located in Minneapolis that provides customized living and 24-hour customized living

- 30.22 services for clients enrolled in the brain injury (BI) or community access for disability
- 30.23 inclusion (CADI) waiver and had a capacity to serve 66 clients as of July 1, 2017, to transfer
- 30.24 service capacity of up to 66 clients to no more than three new housing with services
- 30.25 establishments located in Hennepin County.
- 30.26 (b) Notwithstanding Minnesota Statutes, section 256B.492, the commissioner shall
- 30.27 determine whether the new housing with services establishments described under paragraph
- 30.28 (a) meet the BI and CADI waiver customized living and 24-hour customized living size
- 30.29 limitation exception for clients receiving those services at the new housing with services
- 30.30 establishments described under paragraph (a).

- 31.1 Sec. 23. **DIRECTION TO THE COMMISSIONER.**
- 31.2 (a) The commissioner of human services must ensure that the MnCHOICES 2.0
- 31.3 assessment and support planning tool incorporates a qualitative approach with open-ended
- 31.4 questions and a conversational, culturally sensitive, approach to interviewing that captures
- 31.5 the assessor's professional judgment based on the person's responses.
- 31.6 (b) If the commissioner of human services convenes a working group or consults with
- 31.7 stakeholders for the purposes of modifying the assessment and support planning process or
- 31.8 tool, the commissioner must include members of the disability community, including
- 31.9 representatives of organizations and individuals involved in assessment and support planning.