SENATE
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S.F. No. 74

(SENATE AUTHORS: RELPH, Abeler and Hoffman)

DATE	D-PG	OFFICIAL STATUS
01/10/2019	58	Introduction and first reading Referred to Human Services Reform Finance and Policy
01/14/2019	84	Chief author stricken, shown as co-author Abeler Chief author added Relph
01/17/2019	91	Comm report: To pass and re-referred to Health and Human Services Finance and Policy
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01/31/2019	199a 228	Comm report: To pass as amended and re-refer to Judiciary and Public Safety Finance and Policy Author added Hoffman
02/14/2019		Comm report: To pass as amended and re-refer to Human Services Reform Finance and Policy

A bill for an act

relating to health and human services; modifying policy provisions relating to home care, community supports and continuing care, children and families, licensing, state-operated services, and chemical and mental health; modifying home care licensing requirements; modifying the foster care licensing moratorium; modifying home and community-based licensing standards; modifying the MnCHOICES assessment process; modifying the housing supports program; modifying licensing requirements for mental health providers; modifying background check provisions for mental health providers; requiring reports; amending Minnesota Statutes 2018, sections 144.057, subdivision 3; 144A.43, subdivisions 11, 27, 30, by adding a subdivision; 144A.472, subdivisions 5, 7; 144A.473; 144A.474, subdivision 2; 144A.475, subdivisions 1, 2, 5; 144A.476, subdivision 1; 144A.479, subdivision 7; 144A.4791, subdivisions 1, 3, 6, 7, 8, 9; 144A.4792, subdivisions 1, 2, 5, 10; 144A.4793, subdivision 6; 144A.4796, subdivision 2; 144A.4797, subdivision 3; 144A.4798; 144A.4799, subdivisions 1, 3; 144A.484, subdivision 1; 243.166, subdivision 4b; 245A.03, subdivision 7; 245A.04, subdivision 7, by adding a subdivision; 245A.11, subdivision 2a; 245C.22, subdivisions 4, 5; 245D.03, subdivision 1; 245D.071, subdivision 5; 245D.091, subdivisions 2, 3, 4; 254B.03, subdivision 2; 256.045, subdivision 3; 256B.0659, subdivision 3a; 256B.0911, subdivisions 1a, 3a, 3f, 5, by adding a subdivision; 256B.0915, subdivision 6; 256B.092, subdivision 1b; 256B.0921; 256B.49, subdivisions 13, 14; 256B.4914, subdivision 3; 256I.03, subdivision 8; 256I.04, subdivision 2b, by adding subdivisions; proposing coding for new law in Minnesota Statutes, chapter 245A; repealing Minnesota Statutes 2018, sections 144A.45, subdivision 6; 144A.481; 256I.05, subdivision 3; Minnesota Rules, parts 9530.6800; 9530.6810.

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

ARTICLE 1
HEALTH CARE

Section 1. **PAIN MANAGEMENT.**

(a) The Health Services Policy Committee established under Minnesota Statutes, section 256B.0625, subdivision 3c, shall evaluate and make recommendations on the integration

of nonpharmacologic pain management that are clinically viable and sustainable; reduce or eliminate chronic pain conditions; improve functional status; and prevent addiction and reduce dependence on opiates or other pain medications. The recommendations must be based on best practices for the effective treatment of musculoskeletal pain provided by health practitioners identified in paragraph (b), and covered under medical assistance. Each health practitioner represented under paragraph (b) shall present the minimum best integrated practice recommendations, policies, and scientific evidence for nonpharmacologic treatment options for eliminating pain and improving functional status within their full professional scope. Recommendations for integration of services may include guidance regarding screening for co-occurring behavioral health diagnoses; protocols for communication between all providers treating a unique individual, including protocols for follow-up; and universal mechanisms to assess improvements in functional status.

(b) In evaluating and making recommendations, the Health Services Policy Committee shall consult and collaborate with the following health practitioners: acupuncture practitioners licensed under Minnesota Statutes, chapter 147B; chiropractors licensed under Minnesota Statutes, sections 148.01 to 148.10; physical therapists licensed under Minnesota Statutes, sections 148.68 to 148.78; medical and osteopathic physicians licensed under Minnesota Statutes, chapter 147, and advanced practice registered nurses licensed under Minnesota Statutes, sections 148.171 to 148.285, with experience in providing primary care collaboratively within a multidisciplinary team of health care practitioners who employ nonpharmacologic pain therapies; and psychologists licensed under Minnesota Statutes, section 148.907.

(c) The commissioner shall submit a progress report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 15, 2020, and shall report final recommendations by August 1, 2020. The final report may also contain recommendations for developing and implementing a pilot program to assess the clinical viability, sustainability, and effectiveness of integrated nonpharmacologic, multidisciplinary treatments for managing musculoskeletal pain and improving functional status.

ARTICLE 2
HOME CARE LICENSING

Section 1. Minnesota Statutes 2018, section 144A.43, subdivision 11, is amended to read:

Subd. 11. **Medication administration.** "Medication administration" means performing a set of tasks ~~to ensure a client takes medications, and includes~~ that include the following:

(1) checking the client's medication record;

(2) preparing the medication as necessary;

(3) administering the medication to the client;

(4) documenting the administration or reason for not administering the medication; and

(5) reporting to a registered nurse or appropriate licensed health professional any concerns about the medication, the client, or the client's refusal to take the medication.

Sec. 2. Minnesota Statutes 2018, section 144A.43, is amended by adding a subdivision to read:

Subd. 12a. **Medication reconciliation.** "Medication reconciliation" means the process of identifying the most accurate list of all medications the client is taking, including the name, dosage, frequency, and route by comparing the client record to an external list of medications obtained from the client, hospital, prescriber, or other provider.

Sec. 3. Minnesota Statutes 2018, section 144A.43, subdivision 27, is amended to read:

Subd. 27. **Service ~~plan~~ consent.** "Service ~~plan~~ consent" means the written ~~plan~~ consent between the client or client's representative and the temporary licensee or licensee about the services that will be provided to the client.

Sec. 4. Minnesota Statutes 2018, section 144A.43, subdivision 30, is amended to read:

Subd. 30. **Standby assistance.** "Standby assistance" means the presence of another person ~~within arm's reach to minimize the risk of injury while performing daily activities through physical intervention or cuing~~ to assist a client with an assistive task by providing cues, oversight, and minimal physical assistance.

Sec. 5. Minnesota Statutes 2018, section 144A.472, subdivision 5, is amended to read:

Subd. 5. **~~Transfers prohibited;~~ Changes in ownership.** ~~Any~~ (a) A home care license issued by the commissioner may not be transferred to another party. Before acquiring ownership of or a controlling interest in a home care provider business, a prospective ~~applicant~~ owner must apply for a new ~~temporary~~ license. A change of ownership is a transfer of operational control ~~to a different business entity~~ of the home care provider business and includes:

(1) transfer of the business to a different or new corporation;

(2) in the case of a partnership, the dissolution or termination of the partnership under chapter 323A, with the business continuing by a successor partnership or other entity;

(3) relinquishment of control of the provider to another party, including to a contract management firm that is not under the control of the owner of the business' assets;

(4) transfer of the business by a sole proprietor to another party or entity; or

(5) ~~in the case of a privately held corporation, the change in~~ transfer of ownership or control of 50 percent or more of the ~~outstanding voting stock~~ controlling interest of a home care provider business not covered by clauses (1) to (4).

(b) An employee who was employed by the previous owner of the home care provider business prior to the effective date of a change in ownership under paragraph (a), and who will be employed by the new owner in the same or a similar capacity, shall be treated as if no change in employer occurred, with respect to orientation, training, tuberculosis testing, background studies, and competency testing and training on the policies identified in subdivisions 1, clause (14), and 2, if applicable.

(c) Notwithstanding paragraph (b), a new owner of a home care provider business must ensure that employees of the provider receive and complete training and testing on any provisions of policies that differ from those of the previous owner, within 90 days after the date of the change in ownership.

Sec. 6. Minnesota Statutes 2018, section 144A.472, subdivision 7, is amended to read:

Subd. 7. **Fees; application, change of ownership, ~~and~~ renewal, and failure to notify.** (a) An initial applicant seeking temporary home care licensure must submit the following application fee to the commissioner along with a completed application:

(1) for a basic home care provider, $2,100; or

(2) for a comprehensive home care provider, $4,200.

(b) A home care provider who is filing a change of ownership as required under subdivision 5 must submit the following application fee to the commissioner, along with the documentation required for the change of ownership:

(1) for a basic home care provider, $2,100; or

(2) for a comprehensive home care provider, $4,200.

(c) For the period ending June 30, 2018, a home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner based on revenues derived from

the provision of home care services during the calendar year prior to the year in which the application is submitted, according to the following schedule:

License Renewal Fee

Provider Annual Revenue	**Fee**
greater than $1,500,000	$6,625
greater than $1,275,000 and no more than $1,500,000	$5,797
greater than $1,100,000 and no more than $1,275,000	$4,969
greater than $950,000 and no more than $1,100,000	$4,141
greater than $850,000 and no more than $950,000	$3,727
greater than $750,000 and no more than $850,000	$3,313
greater than $650,000 and no more than $750,000	$2,898
greater than $550,000 and no more than $650,000	$2,485
greater than $450,000 and no more than $550,000	$2,070
greater than $350,000 and no more than $450,000	$1,656
greater than $250,000 and no more than $350,000	$1,242
greater than $100,000 and no more than $250,000	$828
greater than $50,000 and no more than $100,000	$500
greater than $25,000 and no more than $50,000	$400
no more than $25,000	$200

(d) For the period between July 1, 2018, and June 30, 2020, a home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner in an amount that is ten percent higher than the applicable fee in paragraph (c). A home care provider's fee shall be based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted.

(e) Beginning July 1, 2020, a home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted, according to the following schedule:

License Renewal Fee

Provider Annual Revenue	**Fee**
greater than $1,500,000	$7,651
greater than $1,275,000 and no more than $1,500,000	$6,695

greater than $1,100,000 and no more than $1,275,000	$5,739
greater than $950,000 and no more than $1,100,000	$4,783
greater than $850,000 and no more than $950,000	$4,304
greater than $750,000 and no more than $850,000	$3,826
greater than $650,000 and no more than $750,000	$3,347
greater than $550,000 and no more than $650,000	$2,870
greater than $450,000 and no more than $550,000	$2,391
greater than $350,000 and no more than $450,000	$1,913
greater than $250,000 and no more than $350,000	$1,434
greater than $100,000 and no more than $250,000	$957
greater than $50,000 and no more than $100,000	$577
greater than $25,000 and no more than $50,000	$462
no more than $25,000	$231

(f) If requested, the home care provider shall provide the commissioner information to verify the provider's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(g) At each annual renewal, a home care provider may elect to pay the highest renewal fee for its license category, and not provide annual revenue information to the commissioner.

(h) A temporary license or license applicant, or temporary licensee or licensee that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee, shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

(i) The fee for failure to comply with the notification requirements of section 144A.473, subdivision 2, paragraph (c), is $1,000.

(j) Fees and penalties collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund. All fees are nonrefundable. Fees collected under paragraphs (c), (d), and (e) are nonrefundable even if received before July 1, 2017, for temporary licenses or licenses being issued effective July 1, 2017, or later.

Sec. 7. Minnesota Statutes 2018, section 144A.473, is amended to read:

144A.473 ISSUANCE OF TEMPORARY LICENSE AND LICENSE RENEWAL.

Subdivision 1. **Temporary license and renewal of license.** (a) The department shall review each application to determine the applicant's knowledge of and compliance with

Minnesota home care regulations. Before granting a temporary license or renewing a license, the commissioner may further evaluate the applicant or licensee by requesting additional information or documentation or by conducting an on-site survey of the applicant to determine compliance with sections 144A.43 to 144A.482.

(b) Within 14 calendar days after receiving an application for a license, the commissioner shall acknowledge receipt of the application in writing. The acknowledgment must indicate whether the application appears to be complete or whether additional information is required before the application will be considered complete.

(c) Within 90 days after receiving a complete application, the commissioner shall issue a temporary license, renew the license, or deny the license.

(d) The commissioner shall issue a license that contains the home care provider's name, address, license level, expiration date of the license, and unique license number. All licenses, except for temporary licenses issued under subdivision 2, are valid for up to one year from the date of issuance.

Subd. 2. **Temporary license.** (a) For new license applicants, the commissioner shall issue a temporary license for either the basic or comprehensive home care level. A temporary license is effective for up to one year from the date of issuance, except that a temporary license may be extended according to subdivision 3. Temporary licensees must comply with sections 144A.43 to 144A.482.

(b) During the temporary license ~~year~~ period, the commissioner shall survey the temporary licensee within 90 calendar days after the commissioner is notified or has evidence that the temporary licensee is providing home care services.

(c) Within five days of beginning the provision of services, the temporary licensee must notify the commissioner that it is serving clients. The notification to the commissioner may be mailed or e-mailed to the commissioner at the address provided by the commissioner. If the temporary licensee does not provide home care services during the temporary license ~~year~~ period, then the temporary license expires at the end of the ~~year~~ period and the applicant must reapply for a temporary home care license. A temporary licensee who fails to comply with the notification requirements of this paragraph is subject to the fee described in section 144A.472, subdivision 7, paragraph (i).

(d) A temporary licensee may request a change in the level of licensure prior to being surveyed and granted a license by notifying the commissioner in writing and providing additional documentation or materials required to update or complete the changed temporary license application. The applicant must pay the difference between the application fees

when changing from the basic level to the comprehensive level of licensure. No refund will be made if the provider chooses to change the license application to the basic level.

(e) If the temporary licensee notifies the commissioner that the licensee has clients within 45 days prior to the temporary license expiration, the commissioner may extend the temporary license for up to 60 days in order to allow the commissioner to complete the on-site survey required under this section and follow-up survey visits.

Subd. 3. **Temporary licensee survey.** (a) If the temporary licensee is in substantial compliance with the survey, the commissioner shall issue either a basic or comprehensive home care license. If the temporary licensee is not in substantial compliance with the survey, the commissioner shall either: (1) not issue a ~~basic or comprehensive~~ license and ~~there will be no contested hearing right under chapter 14~~ terminate the temporary license; or (2) extend the temporary license for a period not to exceed 90 days and apply conditions, as permitted under section 144A.475, subdivision 2, to the extension of a temporary license. If the temporary licensee is not in substantial compliance with the survey within the time period of the extension, or if the temporary licensee does not satisfy the license conditions, the commissioner may deny the license.

(b) If the temporary licensee whose basic or comprehensive license has been denied or extended with conditions disagrees with the conclusions of the commissioner, then the temporary licensee may request a reconsideration by the commissioner or commissioner's designee. The reconsideration request process must be conducted internally by the commissioner or commissioner's designee, and chapter 14 does not apply.

(c) The temporary licensee requesting reconsideration must make the request in writing and must list and describe the reasons why the temporary licensee disagrees with the decision to deny the basic or comprehensive home care license or the decision to extend the temporary license with conditions.

(d) The reconsideration request and supporting documentation must be received by the commissioner within 15 calendar days after the date the temporary licensee receives the correction order.

(e) A temporary licensee whose license is denied, is permitted to continue operating as a home care provider during the period of time when:

(1) a reconsideration request is in process;

(2) an extension of a temporary license is being negotiated;

(3) the placement of conditions on a temporary license is being negotiated; or

(4) a transfer of home care clients from the temporary licensee to a new home care provider is in process.

(f) A temporary licensee whose license is denied must comply with the requirements for notification and transfer of clients in section 144A.475, subdivision 5.

Sec. 8. Minnesota Statutes 2018, section 144A.474, subdivision 2, is amended to read:

Subd. 2. **Types of home care surveys.** (a) "Initial full survey" means the survey of a new temporary licensee conducted after the department is notified or has evidence that the temporary licensee is providing home care services to determine if the provider is in compliance with home care requirements. Initial full surveys must be completed within 14 months after the department's issuance of a temporary basic or comprehensive license.

(b) "Change in ownership survey" means a full survey of a new licensee due to a change in ownership. Change in ownership surveys must be completed within six months after the department's issuance of a new license due to a change in ownership.

(c) "Core survey" means periodic inspection of home care providers to determine ongoing compliance with the home care requirements, focusing on the essential health and safety requirements. Core surveys are available to licensed home care providers who have been licensed for three years and surveyed at least once in the past three years with the latest survey having no widespread violations beyond Level 1 as provided in subdivision 11. Providers must also not have had any substantiated licensing complaints, substantiated complaints against the agency under the Vulnerable Adults Act or Maltreatment of Minors Act, or an enforcement action as authorized in section 144A.475 in the past three years.

(1) The core survey for basic home care providers must review compliance in the following areas:

(i) reporting of maltreatment;

(ii) orientation to and implementation of the home care bill of rights;

(iii) statement of home care services;

(iv) initial evaluation of clients and initiation of services;

(v) client review and monitoring;

(vi) service ~~plan~~ consent implementation and changes to the service ~~plan~~ consent;

(vii) client complaint and investigative process;

(viii) competency of unlicensed personnel; and

(ix) infection control.

(2) For comprehensive home care providers, the core survey must include everything in the basic core survey plus these areas:

(i) delegation to unlicensed personnel;

(ii) assessment, monitoring, and reassessment of clients; and

(iii) medication, treatment, and therapy management.

~~(c)~~ (d) "Full survey" means the periodic inspection of home care providers to determine ongoing compliance with the home care requirements that cover the core survey areas and all the legal requirements for home care providers. A full survey is conducted for all temporary licensees ~~and~~, for licensees that receive licenses due to an approved change in ownership, for providers who do not meet the requirements needed for a core survey, and when a surveyor identifies unacceptable client health or safety risks during a core survey. A full survey must include all the tasks identified as part of the core survey and any additional review deemed necessary by the department, including additional observation, interviewing, or records review of additional clients and staff.

~~(d)~~ (e) "Follow-up surveys" means surveys conducted to determine if a home care provider has corrected deficient issues and systems identified during a core survey, full survey, or complaint investigation. Follow-up surveys may be conducted via phone, e-mail, fax, mail, or on-site reviews. Follow-up surveys, other than complaint surveys, shall be concluded with an exit conference and written information provided on the process for requesting a reconsideration of the survey results.

~~(e)~~ (f) Upon receiving information alleging that a home care provider has violated or is currently violating a requirement of sections 144A.43 to 144A.482, the commissioner shall investigate the complaint according to sections 144A.51 to 144A.54.

Sec. 9. Minnesota Statutes 2018, section 144A.475, subdivision 1, is amended to read:

Subdivision 1. **Conditions.** (a) The commissioner may refuse to grant a temporary license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the home care provider or owner or managerial official of the home care provider:

(1) is in violation of, or during the term of the license has violated, any of the requirements in sections 144A.471 to 144A.482;

(2) permits, aids, or abets the commission of any illegal act in the provision of home care;

(3) performs any act detrimental to the health, safety, and welfare of a client;

(4) obtains the license by fraud or misrepresentation;

(5) knowingly made or makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;

(6) denies representatives of the department access to any part of the home care provider's books, records, files, or employees;

(7) interferes with or impedes a representative of the department in contacting the home care provider's clients;

(8) interferes with or impedes a representative of the department in the enforcement of this chapter or has failed to fully cooperate with an inspection, survey, or investigation by the department;

(9) destroys or makes unavailable any records or other evidence relating to the home care provider's compliance with this chapter;

(10) refuses to initiate a background study under section 144.057 or 245A.04;

(11) fails to timely pay any fines assessed by the department;

(12) violates any local, city, or township ordinance relating to home care services;

(13) has repeated incidents of personnel performing services beyond their competency level; or

(14) has operated beyond the scope of the home care provider's license level.

(b) A violation by a contractor providing the home care services of the home care provider is a violation by the home care provider.

Sec. 10. Minnesota Statutes 2018, section 144A.475, subdivision 2, is amended to read:

Subd. 2. **Terms to suspension or conditional license.** (a) A suspension or conditional license designation may include terms that must be completed or met before a suspension or conditional license designation is lifted. A conditional license designation may include restrictions or conditions that are imposed on the provider. Terms for a suspension or conditional license may include one or more of the following and the scope of each will be determined by the commissioner:

(1) requiring a consultant to review, evaluate, and make recommended changes to the home care provider's practices and submit reports to the commissioner at the cost of the home care provider;

(2) requiring supervision of the home care provider or staff practices at the cost of the home care provider by an unrelated person who has sufficient knowledge and qualifications to oversee the practices and who will submit reports to the commissioner;

(3) requiring the home care provider or employees to obtain training at the cost of the home care provider;

(4) requiring the home care provider to submit reports to the commissioner;

(5) prohibiting the home care provider from taking any new clients for a period of time; or

(6) any other action reasonably required to accomplish the purpose of this subdivision and section 144A.45, subdivision 2.

(b) A home care provider subject to this subdivision may continue operating during the period of time home care clients are being transferred to other providers.

Sec. 11. Minnesota Statutes 2018, section 144A.475, subdivision 5, is amended to read:

Subd. 5. **Plan required.** (a) The process of suspending or revoking a license must include a plan for transferring affected clients to other providers by the home care provider, which will be monitored by the commissioner. Within three business days of being notified of the final revocation or suspension action, the home care provider shall provide the commissioner, the lead agencies as defined in section 256B.0911, and the ombudsman for long-term care with the following information:

(1) a list of all clients, including full names and all contact information on file;

(2) a list of each client's representative or emergency contact person, including full names and all contact information on file;

(3) the location or current residence of each client;

(4) the payor sources for each client, including payor source identification numbers; and

(5) for each client, a copy of the client's service plan, and a list of the types of services being provided.

(b) The revocation or suspension notification requirement is satisfied by mailing the notice to the address in the license record. The home care provider shall cooperate with the

commissioner and the lead agencies during the process of transferring care of clients to qualified providers. Within three business days of being notified of the final revocation or suspension action, the home care provider must notify and disclose to each of the home care provider's clients, or the client's representative or emergency contact persons, that the commissioner is taking action against the home care provider's license by providing a copy of the revocation or suspension notice issued by the commissioner.

(c) A home care provider subject to this subdivision may continue operating during the period of time home care clients are being transferred to other providers.

Sec. 12. Minnesota Statutes 2018, section 144A.476, subdivision 1, is amended to read:

Subdivision 1. **Prior criminal convictions; owner and managerial officials.** (a) Before the commissioner issues a temporary license, issues a license as a result of an approved change in ownership, or renews a license, an owner or managerial official is required to complete a background study under section 144.057. No person may be involved in the management, operation, or control of a home care provider if the person has been disqualified under chapter 245C. If an individual is disqualified under section 144.057 or chapter 245C, the individual may request reconsideration of the disqualification. If the individual requests reconsideration and the commissioner sets aside or rescinds the disqualification, the individual is eligible to be involved in the management, operation, or control of the provider. If an individual has a disqualification under section 245C.15, subdivision 1, and the disqualification is affirmed, the individual's disqualification is barred from a set aside, and the individual must not be involved in the management, operation, or control of the provider.

(b) For purposes of this section, owners of a home care provider subject to the background check requirement are those individuals whose ownership interest provides sufficient authority or control to affect or change decisions related to the operation of the home care provider. An owner includes a sole proprietor, a general partner, or any other individual whose individual ownership interest can affect the management and direction of the policies of the home care provider.

(c) For the purposes of this section, managerial officials subject to the background check requirement are individuals who provide direct contact as defined in section 245C.02, subdivision 11, or individuals who have the responsibility for the ongoing management or direction of the policies, services, or employees of the home care provider. Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.

(d) The department shall not issue any license if the applicant or owner or managerial official has been unsuccessful in having a background study disqualification set aside under section 144.057 and chapter 245C; if the owner or managerial official, as an owner or managerial official of another home care provider, was substantially responsible for the other home care provider's failure to substantially comply with sections 144A.43 to 144A.482; or if an owner that has ceased doing business, either individually or as an owner of a home care provider, was issued a correction order for failing to assist clients in violation of this chapter.

Sec. 13. Minnesota Statutes 2018, section 144A.479, subdivision 7, is amended to read:

Subd. 7. **Employee records.** The home care provider must maintain current records of each paid employee, regularly scheduled volunteers providing home care services, and of each individual contractor providing home care services. The records must include the following information:

(1) evidence of current professional licensure, registration, or certification, if licensure, registration, or certification is required by this statute or other rules;

(2) records of orientation, required annual training and infection control training, and competency evaluations;

(3) current job description, including qualifications, responsibilities, and identification of staff providing supervision;

(4) documentation of annual performance reviews which identify areas of improvement needed and training needs;

(5) for individuals providing home care services, verification that ~~required~~ any health screenings required by infection control programs established under section 144A.4798 have taken place and the dates of those screenings; and

(6) documentation of the background study as required under section 144.057.

Each employee record must be retained for at least three years after a paid employee, home care volunteer, or contractor ceases to be employed by or under contract with the home care provider. If a home care provider ceases operation, employee records must be maintained for three years.

Sec. 14. Minnesota Statutes 2018, section 144A.4791, subdivision 1, is amended to read:

Subdivision 1. **Home care bill of rights; notification to client.** (a) The home care provider shall provide the client or the client's representative a written notice of the rights under section 144A.44 before the ~~initiation of~~ date that services are first provided to that client. The provider shall make all reasonable efforts to provide notice of the rights to the client or the client's representative in a language the client or client's representative can understand.

(b) In addition to the text of the home care bill of rights in section 144A.44, subdivision 1, the notice shall also contain the following statement describing how to file a complaint with these offices.

"If you have a complaint about the provider or the person providing your home care services, you may call, write, or visit the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities."

The statement should include the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of the Ombudsman for Long-Term Care, and the Office of the Ombudsman for Mental Health and Developmental Disabilities. The statement should also include the home care provider's name, address, e-mail, telephone number, and name or title of the person at the provider to whom problems or complaints may be directed. It must also include a statement that the home care provider will not retaliate because of a complaint.

(c) The home care provider shall obtain written acknowledgment of the client's receipt of the home care bill of rights or shall document why an acknowledgment cannot be obtained. The acknowledgment may be obtained from the client or the client's representative. Acknowledgment of receipt shall be retained in the client's record.

Sec. 15. Minnesota Statutes 2018, section 144A.4791, subdivision 3, is amended to read:

Subd. 3. **Statement of home care services.** Prior to the ~~initiation of~~ date that services are first provided to the client, a home care provider must provide to the client or the client's representative a written statement which identifies if the provider has a basic or comprehensive home care license, the services the provider is authorized to provide, and which services the provider cannot provide under the scope of the provider's license. The home care provider shall obtain written acknowledgment from the clients that the provider

has provided the statement or must document why the provider could not obtain the acknowledgment.

Sec. 16. Minnesota Statutes 2018, section 144A.4791, subdivision 6, is amended to read:

Subd. 6. **Initiation of services.** When a provider ~~initiates~~ provides home care services ~~and~~ to a client before the individualized review or assessment by a licensed health professional or registered nurse as required in subdivisions 7 and 8 ~~has not been~~ is completed, the ~~provider~~ licensed health professional or registered nurse must complete a temporary plan ~~and agreement~~ with the client ~~for services~~ and orient staff assigned to deliver services as identified in the temporary plan.

Sec. 17. Minnesota Statutes 2018, section 144A.4791, subdivision 7, is amended to read:

Subd. 7. **Basic individualized client review and monitoring.** (a) When services being provided are basic home care services, an individualized initial review of the client's needs and preferences must be conducted at the client's residence with the client or client's representative. This initial review must be completed within 30 days after the ~~initiation of the~~ date that home care services are first provided.

(b) Client monitoring and review must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the date of the last review. The monitoring and review may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs.

Sec. 18. Minnesota Statutes 2018, section 144A.4791, subdivision 8, is amended to read:

Subd. 8. **Comprehensive assessment, monitoring, and reassessment.** (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be conducted by the appropriate health professional. This initial assessment must be completed within five days after ~~initiation of~~ the date that home care services are first provided.

(b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after ~~initiation of~~ the date that home care services are first provided.

(c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence

or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs.

Sec. 19. Minnesota Statutes 2018, section 144A.4791, subdivision 9, is amended to read:

Subd. 9. **Service ~~plan~~ consent, implementation, and revisions to service ~~plan~~ consent.** (a) No later than 14 days after the ~~initiation of~~ date that home care services are first provided, a home care provider shall finalize a current written service ~~plan~~ consent.

(b) The service ~~plan~~ consent and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service ~~plan~~ consent must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care.

(c) The home care provider must implement and provide all services required by the current service ~~plan~~ consent.

(d) The service ~~plan~~ consent and revised service ~~plan~~ consent must be entered into the client's record, including notice of a change in a client's fees when applicable.

(e) Staff providing home care services must be informed of the current written service ~~plan~~ consent.

(f) The service ~~plan~~ consent must include:

(1) a description of the home care services to be provided, the fees for services, and the frequency of each service, according to the client's current review or assessment and client preferences;

(2) the identification of the staff or categories of staff who will provide the services;

(3) the schedule and methods of monitoring reviews or assessments of the client;

(4) ~~the frequency of sessions of supervision of staff and type of personnel who will supervise staff~~ the schedule and methods of monitoring staff providing home care services; and

(5) a contingency plan that includes:

(i) the action to be taken by the home care provider and by the client or client's representative if the scheduled service cannot be provided;

(ii) information and a method for a client or client's representative to contact the home care provider;

(iii) names and contact information of persons the client wishes to have notified in an emergency or if there is a significant adverse change in the client's condition~~, including identification of and information as to who has authority to sign for the client in an emergency~~; and

(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the client under those chapters.

Sec. 20. Minnesota Statutes 2018, section 144A.4792, subdivision 1, is amended to read:

Subdivision 1. **Medication management services; comprehensive home care license.** (a) This subdivision applies only to home care providers with a comprehensive home care license that provide medication management services to clients. Medication management services may not be provided by a home care provider who has a basic home care license.

(b) A comprehensive home care provider who provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines.

(c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and client and client representative, if any; disposing of unused medications; and educating clients and client representatives about medications. When controlled substances are being managed, stored, and secured by the comprehensive home care provider, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 22.

Sec. 21. Minnesota Statutes 2018, section 144A.4792, subdivision 2, is amended to read:

Subd. 2. **Provision of medication management services.** (a) For each client who requests medication management services, the comprehensive home care provider shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the client. The assessment must include an identification and review of all medications the client is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.

(b) The assessment must:

(1) identify interventions needed in management of medications to prevent diversion of medication by the client or others who may have access to the medications~~.~~; and

(2) provide instructions to the client or client's representative on interventions to manage the client's medications and prevent diversion of medications.

"Diversion of medications" means the misuse, theft, or illegal or improper disposition of medications.

Sec. 22. Minnesota Statutes 2018, section 144A.4792, subdivision 5, is amended to read:

Subd. 5. **Individualized medication management plan.** (a) For each client receiving medication management services, the comprehensive home care provider must prepare and include in the service ~~plan~~ consent a written statement of the medication management services that will be provided to the client. The provider must develop and maintain a current individualized medication management record for each client based on the client's assessment that must contain the following:

(1) a statement describing the medication management services that will be provided;

(2) a description of storage of medications based on the client's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;

(3) documentation of specific client instructions relating to the administration of medications;

(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;

(5) identification of medication management tasks that may be delegated to unlicensed personnel;

(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and

(7) any client-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.

(b) The medication management record must be current and updated when there are any changes.

(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.

Sec. 23. Minnesota Statutes 2018, section 144A.4792, subdivision 10, is amended to read:

Subd. 10. **Medication management for clients who will be away from home.** (a) A home care provider who is providing medication management services to the client and controls the client's access to the medications must develop and implement policies and procedures for giving accurate and current medications to clients for planned or unplanned times away from home according to the client's individualized medication management plan. The policy and procedures must state that:

(1) for planned time away, the medications must be obtained from the pharmacy or set up by ~~the registered~~ a licensed nurse according to appropriate state and federal laws and nursing standards of practice;

(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall give the client or client's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed ~~120 hours~~ seven calendar days;

(3) the client or client's representative must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances;

(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the client's name and the dates and times that the medications are scheduled; and

(5) the client or client's representative must be provided in writing the home care provider's name and information on how to contact the home care provider.

(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:

(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to clients; and

(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the client. The procedures must address:

(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;

(ii) how the container or containers must be labeled;

(iii) the written information about the medications to be given to the client or client's representative;

(iv) how the unlicensed staff must document in the client's record that medications have been given to the client or the client's representative, including documenting the date the medications were given to the client or the client's representative and who received the medications, the person who gave the medications to the client, the number of medications that were given to the client, and other required information;

(v) how the registered nurse shall be notified that medications have been given to the client or client's representative and whether the registered nurse needs to be contacted before the medications are given to the client or the client's representative; ~~and~~

(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel~~.~~; and

(vii) how the unlicensed staff must document in the client's record any unused medications that are returned to the provider, including the name of each medication and the doses of each returned medication.

Sec. 24. Minnesota Statutes 2018, section 144A.4793, subdivision 6, is amended to read:

Subd. 6. **Treatment and therapy orders ~~or prescriptions.~~** There must be an up-to-date written or electronically recorded order ~~or prescription~~ from an authorized prescriber for all treatments and therapies. The order must contain the name of the client, a description of the treatment or therapy to be provided, and the frequency, duration, and other information

needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.

Sec. 25. Minnesota Statutes 2018, section 144A.4796, subdivision 2, is amended to read:

Subd. 2. **Content.** (a) The orientation must contain the following topics:

(1) an overview of sections 144A.43 to 144A.4798;

(2) introduction and review of all the provider's policies and procedures related to the provision of home care services by the individual staff person;

(3) handling of emergencies and use of emergency services;

(4) compliance with and reporting of the maltreatment of minors or vulnerable adults under sections 626.556 and 626.557;

(5) home care bill of rights under section 144A.44;

(6) handling of clients' complaints, reporting of complaints, and where to report complaints including information on the Office of Health Facility Complaints and the Common Entry Point;

(7) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county managed care advocates, or other relevant advocacy services; and

(8) review of the types of home care services the employee will be providing and the provider's scope of licensure.

(b) In addition to the topics listed in paragraph (a), orientation may also contain training on providing services to clients with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research-based, may include online training, and must include training on one or more of the following topics:

(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;

(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or

(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

Sec. 26. Minnesota Statutes 2018, section 144A.4797, subdivision 3, is amended to read:

Subd. 3. **Supervision of staff providing delegated nursing or therapy home care tasks.** (a) Staff who perform delegated nursing or therapy home care tasks must be supervised by an appropriate licensed health professional or a registered nurse periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the client.

(b) The direct supervision of staff performing delegated tasks must be provided within 30 days after the date on which the individual begins working for the home care provider and first performs delegated tasks for clients and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.

Sec. 27. Minnesota Statutes 2018, section 144A.4798, is amended to read:

144A.4798 ~~EMPLOYEE HEALTH STATUS~~ DISEASE PREVENTION AND INFECTION CONTROL.

Subdivision 1. **Tuberculosis (TB) ~~prevention and~~ infection control.** (a) A home care provider must establish and maintain a ~~TB prevention and~~ comprehensive tuberculosis infection control program ~~based on~~ according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. ~~Components of a TB prevention and control program include screening all staff providing home care services, both paid and unpaid, at the time of hire for active TB disease and latent TB infection, and developing and implementing a written TB infection control plan. The commissioner shall make the most recent CDC standards available to home care providers on the department's website.~~ This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.

(b) Written evidence of compliance with this subdivision must be maintained by the home care provider.

Subd. 2. **Communicable diseases.** A home care provider must follow current ~~federal or~~ state ~~guidelines~~ requirements for prevention, control, and reporting of ~~human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus, or other~~ communicable diseases as defined in Minnesota Rules, ~~part~~ parts 4605.7040, 4605.7044, 4605.7050, 4605.7075, 4605.7080, and 4605.7090.

Subd. 3. **Infection control program.** A home care provider must establish and maintain an effective infection control program that complies with accepted health care, medical, and nursing standards for infection control.

Sec. 28. Minnesota Statutes 2018, section 144A.4799, subdivision 1, is amended to read:

Subdivision 1. **Membership.** The commissioner of health shall appoint eight persons to a home care and assisted living program advisory council consisting of the following:

(1) three public members as defined in section 214.02 who shall be ~~either~~ persons who are currently receiving home care services ~~or~~, persons who have received home care services within five years of the application date, persons who have family members receiving home care services, or persons who have family members who have received home care services within five years of the application date;

(2) three Minnesota home care licensees representing basic and comprehensive levels of licensure who may be a managerial official, an administrator, a supervising registered nurse, or an unlicensed personnel performing home care tasks;

(3) one member representing the Minnesota Board of Nursing; and

(4) one member representing the Office of Ombudsman for Long-Term Care.

Sec. 29. Minnesota Statutes 2018, section 144A.4799, subdivision 3, is amended to read:

Subd. 3. **Duties.** (a) At the commissioner's request, the advisory council shall provide advice regarding regulations of Department of Health licensed home care providers in this chapter, including advice on the following:

(1) community standards for home care practices;

(2) enforcement of licensing standards and whether certain disciplinary actions are appropriate;

(3) ways of distributing information to licensees and consumers of home care;

(4) training standards;

(5) identifying emerging issues and opportunities in ~~the~~ home care ~~field, including~~ and assisted living;

(6) identifying the use of technology in home and telehealth capabilities;

~~(6)~~ (7) allowable home care licensing modifications and exemptions, including a method for an integrated license with an existing license for rural licensed nursing homes to provide limited home care services in an adjacent independent living apartment building owned by the licensed nursing home; and

~~(7)~~ (8) recommendations for studies using the data in section 62U.04, subdivision 4, including but not limited to studies concerning costs related to dementia and chronic disease among an elderly population over 60 and additional long-term care costs, as described in section 62U.10, subdivision 6.

(b) The advisory council shall perform other duties as directed by the commissioner.

(c) The advisory council shall annually review the balance of the account in the state government special revenue fund described in section 144A.474, subdivision 11, paragraph (i), and make annual recommendations by January 15 directly to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services regarding appropriations to the commissioner for the purposes in section 144A.474, subdivision 11, paragraph (i).

Sec. 30. Minnesota Statutes 2018, section 144A.484, subdivision 1, is amended to read:

Subdivision 1. **Integrated licensing established.** ~~(a) From January 1, 2014, to June 30, 2015, the commissioner of health shall enforce the home and community-based services standards under chapter 245D for those providers who also have a home care license pursuant to this chapter as required under Laws 2013, chapter 108, article 8, section 60, and article 11, section 31. During this period, the commissioner shall provide technical assistance to achieve and maintain compliance with applicable law or rules governing the provision of home and community-based services, including complying with the service recipient rights notice in subdivision 4, clause (4). If during the survey, the commissioner finds that the licensee has failed to achieve compliance with an applicable law or rule under chapter 245D and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the commissioner may issue a licensing survey report with recommendations for achieving and maintaining compliance.~~

~~(b) Beginning July 1, 2015,~~ A home care provider applicant or license holder may apply to the commissioner of health for a home and community-based services designation for

the provision of basic support services identified under section 245D.03, subdivision 1, paragraph (b). The designation allows the license holder to provide basic support services that would otherwise require licensure under chapter 245D, under the license holder's home care license governed by sections 144A.43 to ~~144A.481~~ 144A.4799.

Sec. 31. **REVISOR INSTRUCTIONS.**

(a) The revisor of statutes shall change the terms "service plan or service agreement" and "service agreement or service plan" to "service consent" in Minnesota Statutes, sections 144A.442; 144D.045; 144G.03, subdivision 4, paragraph (c); and 144G.04.

(b) The revisor of statutes shall change the term "service plan" to "service consent" and the term "service plans" to "service consents" in Minnesota Statutes, sections 144A.44; 144A.45; 144A.475; 144A.4791; 144A.4792; 144A.4793; 144A.4794; 144D.04; and 144G.03, subdivision 4, paragraph (a).

Sec. 32. **REPEALER.**

Minnesota Statutes 2018, sections 144A.45, subdivision 6; and 144A.481, are repealed.

ARTICLE 3
COMMUNITY SUPPORTS AND CONTINUING CARE

Section 1. Minnesota Statutes 2018, section 245A.03, subdivision 7, is amended to read:

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

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

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

(3) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD, or regional treatment center; restructuring of state-operated services that limits the capacity of state-operated facilities; or allowing movement to the community for people who no longer require the level of care provided in state-operated facilities as provided under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

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

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

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

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

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

(7) new foster care licenses or community residential setting licenses for people receiving services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and for which a license is required. This exception does not apply to people living in their own home. For purposes of this clause, there is a presumption that a foster care or community residential setting license is required for services provided to three or more people in a dwelling unit when the setting is controlled by the provider. A license holder subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for

reconsideration is final and not subject to appeal under chapter 14. The exception is available until June 30, ~~2018~~ 2019. This exception is available when:

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

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

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

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

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

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

(e) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity determined under section 256B.493 will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet the

informed decisions of those people who want to move out of corporate foster care or community residential settings, long-term service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term services and supports reports and statewide data and information.

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

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

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

(i) The commissioner must notify a license holder when its corporate foster care or community residential setting licensed beds are reduced under this section. The notice of reduction of licensed beds must be in writing and delivered to the license holder by certified mail or personal service. The notice must state why the licensed beds are reduced and must inform the license holder of its right to request reconsideration by the commissioner. The license holder's request for reconsideration must be in writing. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 20 calendar days

after the license holder's receipt of the notice of reduction of licensed beds. If a request for reconsideration is made by personal service, it must be received by the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

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

EFFECTIVE DATE. This section is effective retroactively from July 1, 2018, and applies to exception requests made on or after that date.

Sec. 2. Minnesota Statutes 2018, section 245A.11, subdivision 2a, is amended to read:

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

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

(c) The commissioner may grant variances to paragraph (b) to allow a facility with a licensed capacity of up to five persons to admit an individual under the age of 55 if the variance complies with section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed facility is located.

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

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

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

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

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

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

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

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

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

(i) individualized plan of care;

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

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

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

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

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

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 3. Minnesota Statutes 2018, section 245D.03, subdivision 1, is amended to read:

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

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

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

(2) adult companion services as defined under the brain injury, community access for disability inclusion, community alternative care, and elderly waiver plans, excluding adult

companion services provided under the Corporation for National and Community Services Senior Companion Program established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

(3) personal support as defined under the brain injury, community access for disability inclusion, community alternative care, and developmental ~~disability~~ disabilities waiver ~~plan~~ plans;

(4) 24-hour emergency assistance, personal emergency response as defined under the brain injury, community access for disability inclusion, community alternative care, and developmental ~~disability~~ disabilities waiver plans;

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

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

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

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

(1) intervention services, including:

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

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

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

(2) in-home support services, including:

(i) in-home family support and supported living services as defined under the brain injury, community access for disability inclusion, community alternative care, and developmental ~~disability~~ disabilities waiver ~~plan~~ plans;

(ii) supported living services as defined under the developmental disabilities waiver plan;

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

~~(iii)~~ (iv) semi-independent living services; and

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

(3) residential supports and services, including:

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

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

(iii) residential services provided to more than four persons with developmental disabilities in a supervised living facility, including ICFs/DD;

(4) day services, including:

(i) structured day services as defined under the brain injury waiver plan;

(ii) day training and habilitation services under sections 252.41 to 252.46, and as defined under the developmental ~~disability~~ disabilities waiver plan; and

(iii) prevocational services as defined under the brain injury and community access for disability inclusion waiver plans; and

(5) employment exploration services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental ~~disability~~ disabilities waiver plans;

(6) employment development services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental ~~disability~~ disabilities waiver plans; and

(7) employment support services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental ~~disability~~ disabilities waiver plans.

Sec. 4. Minnesota Statutes 2018, section 245D.071, subdivision 5, is amended to read:

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

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

~~(b)~~ (c) The license holder must summarize the person's status and progress toward achieving the identified outcomes and make recommendations and identify the rationale for changing, continuing, or discontinuing implementation of supports and methods identified

in subdivision 4 in a report available at the time of the progress review meeting. The report must be sent at least five working days prior to the progress review meeting if requested by the team in the coordinated service and support plan or coordinated service and support plan addendum.

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

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

Sec. 5. Minnesota Statutes 2018, section 245D.091, subdivision 2, is amended to read:

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

(1) ethical considerations;

(2) functional assessment;

(3) functional analysis;

(4) measurement of behavior and interpretation of data;

(5) selecting intervention outcomes and strategies;

(6) behavior reduction and elimination strategies that promote least restrictive approved alternatives;

(7) data collection;

(8) staff and caregiver training;

(9) support plan monitoring;

(10) co-occurring mental disorders or neurocognitive disorder;

(11) demonstrated expertise with populations being served; and

(12) must be a:

(i) psychologist licensed under sections 148.88 to 148.98, who has stated to the Board of Psychology competencies in the above identified areas;

(ii) clinical social worker licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the areas identified in clauses (1) to (11);

(iii) physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry with competencies in the areas identified in clauses (1) to (11);

(iv) licensed professional clinical counselor licensed under sections 148B.29 to 148B.39 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services who has demonstrated competencies in the areas identified in clauses (1) to (11);

(v) person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services with demonstrated competencies in the areas identified in clauses (1) to (11); ~~or~~

(vi) person with a master's degree or PhD in one of the behavioral sciences or related fields with demonstrated expertise in positive support services; or

(vii) registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization, or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services.

Sec. 6. Minnesota Statutes 2018, section 245D.091, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 7. Minnesota Statutes 2018, section 245D.091, subdivision 4, is amended to read:

Subd. 4. **~~Behavior~~ Positive support specialist qualifications.** (a) A ~~behavior~~ positive support specialist providing ~~behavioral~~ positive support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the following areas as required under the brain injury ~~and~~, community access for disability inclusion, community alternative care, and developmental disabilities waiver plans or successor plans:

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

(2) have two years of supervised experience working with individuals who exhibit challenging behaviors as well as co-occurring mental disorders or neurocognitive disorder.

(b) In addition, a behavior specialist must:

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

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

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

~~(3) have received~~ (iii) ten hours of instruction on design of positive practices behavioral support strategies; and

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

~~(4)~~ (2) be determined by a ~~behavior~~ positive support professional to have the training and prerequisite skills required to provide positive practices strategies as well as behavior

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

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

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

Sec. 8. Minnesota Statutes 2018, section 256B.0659, subdivision 3a, is amended to read:

Subd. 3a. **Assessment; defined.** (a) "Assessment" means a review and evaluation of a recipient's need for personal care assistance services conducted in person. Assessments for personal care assistance services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county except when a long-term care consultation assessment is being conducted for the purposes of determining a person's eligibility for home and community-based waiver services including personal care assistance services according to section 256B.0911. During the transition to MnCHOICES, a certified assessor may complete the assessment defined in this subdivision. An in-person assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistance services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. An in-person assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistance services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistance service. A service update may be completed by telephone, used when there is no need for an increase in personal care assistance services, and used for two consecutive assessments if followed by a face-to-face assessment. A service update must be completed on a form approved by the commissioner. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments or reassessments must be completed on forms provided by the

commissioner within 30 days of a request for home care services by a recipient or responsible party.

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

Sec. 9. Minnesota Statutes 2018, section 256B.0911, subdivision 1a, is amended to read:

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

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

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

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

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

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

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

(6) determination of home and community-based waiver and other service eligibility as required under sections 256B.0913, 256B.0915, 256B.092, and 256B.49, including level of care determination for individuals who need an institutional level of care as determined under subdivision 4e, based on assessment and community support plan development, appropriate referrals to obtain necessary diagnostic information, and including an eligibility determination for consumer-directed community supports;

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

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

(9) providing information about competitive employment, with or without supports, for school-age youth and working-age adults and referrals to the Disability Linkage Line and Disability Benefits 101 to ensure that an informed choice about competitive employment can be made. For the purposes of this subdivision, "competitive employment" means work

in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting, and for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

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

(1) service eligibility determination for state plan ~~home care~~ services identified in:

(i) section 256B.0625, subdivisions ~~7,~~ 19a~~,~~ and 19c;

(ii) consumer support grants under section 256.476; or

(iii) section 256B.85;

(2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024, ~~determination of eligibility for~~ gaining access to case management services available under sections 256B.0621, subdivision 2, ~~paragraph~~ clause (4), ~~and~~ 256B.0924, and Minnesota Rules, part 9525.0016;

(3) determination ~~of institutional level of care, home and community-based service waiver, and other service~~ of eligibility ~~as required under section 256B.092, determination of eligibility for family support grants under section 252.32,~~ for semi-independent living services under section 252.275~~, and day training and habilitation services under section 256B.092~~; and

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

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

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

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

(f) "Person-centered planning" is a process that includes the active participation of a person in the planning of the person's services, including in making meaningful and informed

choices about the person's own goals, talents, and objectives, as well as making meaningful and informed choices about the services the person receives. For the purposes of this section, "informed choice" means a voluntary choice of services by a person from all available service options based on accurate and complete information concerning all available service options and concerning the person's own preferences, abilities, goals, and objectives. In order for a person to make an informed choice, all available options must be developed and presented to the person to empower the person to make decisions.

Sec. 10. Minnesota Statutes 2018, section 256B.0911, subdivision 3a, is amended to read:

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

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

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

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

256B.0915, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment. For a person who is to be assessed for waiver services under section 256B.092 or 256B.49, with the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs prepared by a direct service employee who is familiar with ~~at least 20 hours of service to that client. The person conducting the assessment or reassessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment and the person or the person's legal representative, and must be considered prior to the finalization of the assessment or reassessment~~ the person. The provider must submit the report at least 60 days before the end of the person's current service agreement. The certified assessor must consider the content of the submitted report prior to finalizing the person's assessment or reassessment.

(e) The certified assessor and the individual responsible for developing the coordinated service and support plan must complete the community support plan and the coordinated service and support plan no more than 60 calendar days from the assessment visit. The person or the person's legal representative must be provided with a written community support plan within ~~40 calendar days of the assessment visit~~ the timelines established by the commissioner, regardless of whether the ~~individual~~ person is eligible for Minnesota health care programs.

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

(g) The written community support plan must include:

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

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

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

(4) referral information; and

(5) informal caregiver supports, if applicable.

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

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

(i) The person has the right to make the final decision between institutional placement and community placement after the recommendations have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d).

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

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

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

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

(4) the role of long-term care consultation assessment and support planning in eligibility determination for waiver and alternative care programs, and state plan home care, case

management, and other services as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(5) information about Minnesota health care programs;

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

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

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

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

(k) Face-to-face assessment completed as part of eligibility determination for the alternative care, elderly waiver, developmental disabilities, community access for disability inclusion, community alternative care, and brain injury waiver programs under sections 256B.0913, 256B.0915, 256B.092, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment.

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

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

(n) At the time of reassessment, the certified assessor shall assess each person receiving waiver services currently residing in a community residential setting, or licensed adult foster care home that is not the primary residence of the license holder, or in which the license holder is not the primary caregiver, to determine if that person would prefer to be served in a community-living setting as defined in section 256B.49, subdivision 23. The certified assessor shall offer the person, through a person-centered planning process, the option to receive alternative housing and service options.

Sec. 11. Minnesota Statutes 2018, section 256B.0911, subdivision 3f, is amended to read:

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

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

Sec. 12. Minnesota Statutes 2018, section 256B.0911, is amended by adding a subdivision to read:

Subd. 3g. **Assessments for Rule 185 case management.** Unless otherwise required by federal law, the county agency is not required to conduct or arrange for an annual needs reassessment by a certified assessor. The case manager who works on behalf of the person

to identify the person's needs and to minimize the impact of the disability on the person's life must instead develop a person-centered service plan based on the person's assessed needs and preferences. The person-centered service plan must be reviewed annually for persons with developmental disabilities who are receiving only case management services under Minnesota Rules, part 9525.0036, and who make an informed choice to decline an assessment under this section.

Sec. 13. Minnesota Statutes 2018, section 256B.0911, subdivision 5, is amended to read:

Subd. 5. **Administrative activity.** (a) The commissioner shall streamline the processes, including timelines for when assessments need to be completed, required to provide the services in this section and shall implement integrated solutions to automate the business processes to the extent necessary for community support plan approval, reimbursement, program planning, evaluation, and policy development.

(b) The commissioner of human services shall work with lead agencies responsible for conducting long-term consultation services to modify the MnCHOICES application and assessment policies to create efficiencies while ensuring federal compliance with medical assistance and long-term services and supports eligibility criteria.

(c) The commissioner shall work with lead agencies responsible for conducting long-term consultation services to develop a set of measurable benchmarks sufficient to demonstrate quarterly improvement in the average time per assessment and other mutually agreed upon measures of increasing efficiency. The commissioner shall collect data on these benchmarks and provide to the lead agencies and the chairs and ranking minority members of the legislative committees with jurisdiction over human services an annual trend analysis of the data in order to demonstrate the commissioner's compliance with the requirements of this subdivision.

Sec. 14. Minnesota Statutes 2018, section 256B.0915, subdivision 6, is amended to read:

Subd. 6. **Implementation of coordinated service and support plan.** (a) Each elderly waiver client shall be provided a copy of a written coordinated service and support plan ~~which~~ that:

(1) is developed with and signed by the recipient within ~~ten working days after the case manager receives the assessment information and written community support plan as described in section 256B.0911, subdivision 3a, from the certified assessor~~ the timelines established by the commissioner. The timeline for completing the community support plan

under section 256B.0911, subdivision 3a, and the coordinated service and support plan must not exceed 60 calendar days from the assessment visit;

(2) includes the person's need for service and identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

(3) reasonably ensures the health and welfare of the recipient;

(4) identifies the person's preferences for services as stated by the person or the person's legal guardian or conservator;

(5) reflects the person's informed choice between institutional and community-based services, as well as choice of services, supports, and providers, including available case manager providers;

(6) identifies long-range and short-range goals for the person;

(7) identifies specific services and the amount, frequency, duration, and cost of the services to be provided to the person based on assessed needs, preferences, and available resources;

(8) includes information about the right to appeal decisions under section 256.045; and

(9) includes the authorized annual and estimated monthly amounts for the services.

(b) In developing the coordinated service and support plan, the case manager should also include the use of volunteers, religious organizations, social clubs, and civic and service organizations to support the individual in the community. The lead agency must be held harmless for damages or injuries sustained through the use of volunteers and agencies under this paragraph, including workers' compensation liability.

Sec. 15. Minnesota Statutes 2018, section 256B.092, subdivision 1b, is amended to read:

Subd. 1b. **Coordinated service and support plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written coordinated service and support plan ~~which~~ that:

(1) is developed with and signed by the recipient within ~~ten working days after the case manager receives the assessment information and written community support plan as described in section 256B.0911, subdivision 3a, from the certified assessor~~ the timelines established by the commissioner. The timeline for completing the community support plan under section 256B.0911, subdivision 3a, and the coordinated service and support plan must not exceed 60 calendar days from the assessment visit;

(2) includes the person's need for service, including identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

(3) reasonably ensures the health and welfare of the recipient;

(4) identifies the person's preferences for services as stated by the person, the person's legal guardian or conservator, or the parent if the person is a minor, including the person's choices made on self-directed options and on services and supports to achieve employment goals;

(5) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (o), of service and support providers, and identifies all available options for case management services and providers;

(6) identifies long-range and short-range goals for the person;

(7) identifies specific services and the amount and frequency of the services to be provided to the person based on assessed needs, preferences, and available resources. The coordinated service and support plan shall also specify other services the person needs that are not available;

(8) identifies the need for an individual program plan to be developed by the provider according to the respective state and federal licensing and certification standards, and additional assessments to be completed or arranged by the provider after service initiation;

(9) identifies provider responsibilities to implement and make recommendations for modification to the coordinated service and support plan;

(10) includes notice of the right to request a conciliation conference or a hearing under section 256.045;

(11) is agreed upon and signed by the person, the person's legal guardian or conservator, or the parent if the person is a minor, and the authorized county representative;

(12) is reviewed by a health professional if the person has overriding medical needs that impact the delivery of services; and

(13) includes the authorized annual and monthly amounts for the services.

(b) In developing the coordinated service and support plan, the case manager is encouraged to include the use of volunteers, religious organizations, social clubs, and civic and service organizations to support the individual in the community. The lead agency must

be held harmless for damages or injuries sustained through the use of volunteers and agencies under this paragraph, including workers' compensation liability.

(c) Approved, written, and signed changes to a consumer's services that meet the criteria in this subdivision shall be an addendum to that consumer's individual service plan.

Sec. 16. Minnesota Statutes 2018, section 256B.0921, is amended to read:

256B.0921 HOME AND COMMUNITY-BASED SERVICES ~~INCENTIVE~~ INNOVATION POOL.

The commissioner of human services shall develop an initiative to provide incentives for innovation in: (1) achieving integrated competitive employment; (2) achieving integrated competitive employment for youth under age 25 upon their graduation from school; (3) living in the most integrated setting; and (4) other outcomes determined by the commissioner. The commissioner shall seek requests for proposals and shall contract with one or more entities to provide incentive payments for meeting identified outcomes.

Sec. 17. Minnesota Statutes 2018, section 256B.49, subdivision 13, is amended to read:

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

(1) finalizing the written coordinated service and support plan within ~~ten working days after the case manager receives the plan from the certified assessor~~ the timelines established by the commissioner. The timeline for completing the community support plan under section 256B.0911, subdivision 3a, and the coordinated service and support plan must not exceed 60 calendar days from the assessment visit;

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

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

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

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

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

(1) finalizing the coordinated service and support plan;

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

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

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

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

(1) phasing out the use of prohibited procedures;

(2) acquisition of skills needed to eliminate the prohibited procedures within the plan's timeline; and

(3) accomplishment of identified outcomes.

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

Sec. 18. Minnesota Statutes 2018, section 256B.49, subdivision 14, is amended to read:

Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments shall be conducted by certified assessors according to section 256B.0911, subdivision 2b. The certified assessor, with the permission of the recipient or the recipient's designated legal

representative, may invite other individuals to attend the assessment. With the permission of the recipient or the recipient's designated legal representative, the recipient's current provider of services may submit a written report outlining their recommendations regarding the recipient's care needs prepared by a direct service employee ~~with at least 20 hours of service to that client. The certified assessor must notify the provider of the date by which this information is to be submitted. This information shall be provided to the certified assessor and the person or the person's legal representative and must be considered prior to the finalization of the assessment or reassessment~~ who is familiar with the person. The provider must submit the report at least 60 days before the end of the person's current service agreement. The certified assessor must consider the content of the submitted report prior to finalizing the person's assessment or reassessment.

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

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

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

Sec. 19. Minnesota Statutes 2018, section 256B.4914, subdivision 3, is amended to read:

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

(1) 24-hour customized living;

(2) adult day care;

(3) adult day care bath;

~~(4) behavioral programming;~~

~~(5)~~ (4) companion services;

~~(6)~~ (5) customized living;

~~(7)~~ (6) day training and habilitation;

(7) employment development services;

(8) employment exploration services;

(9) employment support services;

~~(8)~~ (10) housing access coordination;

~~(9)~~ (11) independent living skills;

(12) independent living skills specialist services;

(13) individualized home supports;

~~(10)~~ (14) in-home family support;

~~(11)~~ (15) night supervision;

~~(12)~~ (16) personal support;

(17) positive support service;

~~(13)~~ (18) prevocational services;

~~(14)~~ (19) residential care services;

~~(15)~~ (20) residential support services;

~~(16)~~ (21) respite services;

~~(17)~~ (22) structured day services;

~~(18)~~ (23) supported employment services;

~~(19)~~ (24) supported living services;

~~(20)~~ (25) transportation services; and

~~(21) individualized home supports;~~

~~(22) independent living skills specialist services;~~

~~(23) employment exploration services;~~

~~(24) employment development services;~~

~~(25) employment support services; and~~

(26) other services as approved by the federal government in the state home and community-based services plan.

Sec. 20. Minnesota Statutes 2018, section 256I.03, subdivision 8, is amended to read:

Subd. 8. **Supplementary services.** "Supplementary services" means housing support services provided to individuals in addition to room and board including, but not limited to, oversight and up to 24-hour supervision, medication reminders, assistance with transportation, arranging for meetings and appointments, and arranging for medical and social services, and services identified in section 256I.03, subdivision 12.

Sec. 21. Minnesota Statutes 2018, section 256I.04, subdivision 2b, is amended to read:

Subd. 2b. **Housing support agreements.** (a) Agreements between agencies and providers of housing support must be in writing on a form developed and approved by the commissioner and must specify the name and address under which the establishment subject to the agreement does business and under which the establishment, or service provider, if different from the group residential housing establishment, is licensed by the Department of Health or the Department of Human Services; the specific license or registration from the Department of Health or the Department of Human Services held by the provider and the number of beds subject to that license; the address of the location or locations at which group residential housing is provided under this agreement; the per diem and monthly rates that are to be paid from housing support funds for each eligible resident at each location; the number of beds at each location which are subject to the agreement; whether the license holder is a not-for-profit corporation under section 501(c)(3) of the Internal Revenue Code; and a statement that the agreement is subject to the provisions of sections 256I.01 to 256I.06 and subject to any changes to those sections.

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

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

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

(3) the provision of housing support;

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

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

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

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

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

Sec. 22. Minnesota Statutes 2018, section 256I.04, is amended by adding a subdivision to read:

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

Sec. 23. Minnesota Statutes 2018, section 256I.04, is amended by adding a subdivision to read:

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

Sec. 24. **DIRECTION TO COMMISSIONER; BI AND CADI WAIVER CUSTOMIZED LIVING SERVICES PROVIDER LOCATED IN HENNEPIN COUNTY.**

(a) The commissioner of human services shall allow a housing with services establishment located in Minneapolis that provides customized living and 24-hour customized living services for clients enrolled in the brain injury (BI) or community access for disability inclusion (CADI) waiver and had a capacity to serve 66 clients as of July 1, 2017, to transfer service capacity of up to 66 clients to no more than three new housing with services establishments located in Hennepin County.

(b) Notwithstanding Minnesota Statutes, section 256B.492, the commissioner shall determine whether the new housing with services establishments described under paragraph (a) meet the BI and CADI waiver customized living and 24-hour customized living size limitation exception for clients receiving those services at the new housing with services establishments described under paragraph (a).

Sec. 25. **DIRECTION TO COMMISSIONER.**

(a) The commissioner of human services must ensure that the MnCHOICES 2.0 assessment and support planning tool incorporates a qualitative approach with open-ended questions and a conversational, culturally sensitive approach to interviewing that captures the assessor's professional judgment based on the person's responses.

(b) If the commissioner of human services convenes a working group or consults with stakeholders for the purposes of modifying the assessment and support planning process or tool, the commissioner must include members of the disability community, including representatives of organizations and individuals involved in assessment and support planning.

Sec. 26. **REVISOR INSTRUCTION.**

The revisor of statutes shall change the term "developmental disability waiver" or similar terms to "developmental disabilities waiver" or similar terms wherever they appear in Minnesota Statutes. The revisor shall also make technical and other necessary changes to sentence structure to preserve the meaning of the text.

Sec. 27. **REPEALER.**

Minnesota Statutes 2018, section 256I.05, subdivision 3, is repealed.

ARTICLE 4
MISCELLANEOUS

Section 1. Minnesota Statutes 2018, section 243.166, subdivision 4b, is amended to read:

Subd. 4b. **Health care facility; notice of status.** (a) For the purposes of this subdivision~~.~~:

(1) "health care facility" means a facility:

~~(1)~~ (i) licensed by the commissioner of health as a hospital, boarding care home or supervised living facility under sections 144.50 to 144.58, or a nursing home under chapter 144A;

~~(2)~~ (ii) registered by the commissioner of health as a housing with services establishment as defined in section 144D.01; or

~~(3)~~ (iii) licensed by the commissioner of human services as a residential facility under chapter 245A to provide adult foster care, adult mental health treatment, chemical dependency treatment to adults, or residential services to persons with disabilities~~.~~; and

(2) "home care provider" has the meaning given in section 144A.43.

(b) Prior to admission to a health care facility or home care services from a home care provider, a person required to register under this section shall disclose to:

(1) the health care facility employee or the home care provider processing the admission the person's status as a registered predatory offender under this section; and

(2) the person's corrections agent, or if the person does not have an assigned corrections agent, the law enforcement authority with whom the person is currently required to register, that ~~inpatient~~ admission will occur.

(c) A law enforcement authority or corrections agent who receives notice under paragraph (b) or who knows that a person required to register under this section is planning to be admitted and receive, or has been admitted and is receiving health care at a health care facility or home care services from a home care provider, shall notify the administrator of the facility or the home care provider and deliver a fact sheet to the administrator or provider containing the following information: (1) name and physical description of the offender; (2) the offender's conviction history, including the dates of conviction; (3) the risk level classification assigned to the offender under section 244.052, if any; and (4) the profile of likely victims.

(d) Except for a hospital licensed under sections 144.50 to 144.58, if a health care facility receives a fact sheet under paragraph (c) that includes a risk level classification for the offender, and if the facility admits the offender, the facility shall distribute the fact sheet to all residents at the facility. If the facility determines that distribution to a resident is not appropriate given the resident's medical, emotional, or mental status, the facility shall distribute the fact sheet to the patient's next of kin or emergency contact.

(e) If a home care provider receives a fact sheet under paragraph (c) that includes a risk level classification for the offender, the provider shall distribute the fact sheet to any individual who will provide direct services to the offender before the individual begins to provide the service.

ARTICLE 5
CHILDREN AND FAMILIES

Section 1. **REVISOR INSTRUCTION.**

The revisor of statutes, in consultation with the Department of Human Services, House Research Department, and Senate Counsel, Research and Fiscal Analysis shall change the terms "food support" and "food stamps" to "Supplemental Nutrition Assistance Program"

or "SNAP" in Minnesota Statutes when appropriate. The revisor may make technical and other necessary changes to sentence structure to preserve the meaning of the text.

ARTICLE 6
STATE-OPERATED SERVICES; CHEMICAL AND MENTAL HEALTH

Section 1. Minnesota Statutes 2018, section 144.057, subdivision 3, is amended to read:

Subd. 3. **Reconsiderations.** The commissioner of health shall review and decide reconsideration requests, including the granting of variances, in accordance with the procedures and criteria contained in chapter 245C. The commissioner must set aside a disqualification for an individual who requests reconsideration and who meets the criteria described in section 245C.22, subdivision 4, paragraph (d). The commissioner's decision shall be provided to the individual and to the Department of Human Services. The commissioner's decision to grant or deny a reconsideration of disqualification is the final administrative agency action, except for the provisions under sections 245C.25, 245C.27, and 245C.28, subdivision 3.

Sec. 2. Minnesota Statutes 2018, section 245A.04, subdivision 7, is amended to read:

Subd. 7. **Grant of license; license extension.** (a) If the commissioner determines that the program complies with all applicable rules and laws, the commissioner shall issue a license consistent with this section or, if applicable, a temporary change of ownership license under section 245A.043. At minimum, the license shall state:

(1) the name of the license holder;

(2) the address of the program;

(3) the effective date and expiration date of the license;

(4) the type of license;

(5) the maximum number and ages of persons that may receive services from the program; and

(6) any special conditions of licensure.

(b) The commissioner may issue ~~an initial~~ a license for a period not to exceed two years if:

(1) the commissioner is unable to conduct the evaluation or observation required by subdivision 4, paragraph (a), clauses (3) and (4), because the program is not yet operational;

(2) certain records and documents are not available because persons are not yet receiving services from the program; and

(3) the applicant complies with applicable laws and rules in all other respects.

(c) A decision by the commissioner to issue a license does not guarantee that any person or persons will be placed or cared for in the licensed program. ~~A license shall not be transferable to another individual, corporation, partnership, voluntary association, other organization, or controlling individual or to another location.~~

~~(d) A license holder must notify the commissioner and obtain the commissioner's approval before making any changes that would alter the license information listed under paragraph (a).~~

~~(e)~~ (d) Except as provided in paragraphs ~~(g)~~ (f) and ~~(h)~~ (g), the commissioner shall not issue or reissue a license if the applicant, license holder, or controlling individual has:

(1) been disqualified and the disqualification was not set aside and no variance has been granted;

(2) been denied a license within the past two years;

(3) had a license issued under this chapter revoked within the past five years;

(4) an outstanding debt related to a license fee, licensing fine, or settlement agreement for which payment is delinquent; or

(5) failed to submit the information required of an applicant under subdivision 1, paragraph (f) or (g), after being requested by the commissioner.

When a license issued under this chapter is revoked under clause (1) or (3), the license holder and controlling individual may not hold any license under chapter 245A or 245D for five years following the revocation, and other licenses held by the applicant, license holder, or controlling individual shall also be revoked.

~~(f)~~ (e) The commissioner shall not issue or reissue a license under this chapter if an individual living in the household where the ~~licensed~~ services will be provided as specified under section 245C.03, subdivision 1, has been disqualified and the disqualification has not been set aside and no variance has been granted.

~~(g)~~ (f) Pursuant to section 245A.07, subdivision 1, paragraph (b), when a license issued under this chapter has been suspended or revoked and the suspension or revocation is under appeal, the program may continue to operate pending a final order from the commissioner. If the license under suspension or revocation will expire before a final order is issued, a

temporary provisional license may be issued provided any applicable license fee is paid before the temporary provisional license is issued.

~~(h)~~ (g) Notwithstanding paragraph ~~(g)~~ (f), when a revocation is based on the disqualification of a controlling individual or license holder, and the controlling individual or license holder is ordered under section 245C.17 to be immediately removed from direct contact with persons receiving services or is ordered to be under continuous, direct supervision when providing direct contact services, the program may continue to operate only if the program complies with the order and submits documentation demonstrating compliance with the order. If the disqualified individual fails to submit a timely request for reconsideration, or if the disqualification is not set aside and no variance is granted, the order to immediately remove the individual from direct contact or to be under continuous, direct supervision remains in effect pending the outcome of a hearing and final order from the commissioner.

~~(i)~~ (h) For purposes of reimbursement for meals only, under the Child and Adult Care Food Program, Code of Federal Regulations, title 7, subtitle B, chapter II, subchapter A, part 226, relocation within the same county by a licensed family day care provider, shall be considered an extension of the license for a period of no more than 30 calendar days or until the new license is issued, whichever occurs first, provided the county agency has determined the family day care provider meets licensure requirements at the new location.

~~(j)~~ (i) Unless otherwise specified by statute, all licenses issued under this chapter expire at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must apply for and be granted a new license to operate the program or the program must not be operated after the expiration date.

~~(k)~~ (j) The commissioner shall not issue or reissue a license under this chapter if it has been determined that a tribal licensing authority has established jurisdiction to license the program or service.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 3. Minnesota Statutes 2018, section 245A.04, is amended by adding a subdivision to read:

Subd. 7a. **Notification required.** (a) A license holder must notify the commissioner and obtain the commissioner's approval before making any change that would alter the license information listed under subdivision 7, paragraph (a).

(b) At least 30 days before the effective date of a change, the license holder must notify the commissioner in writing of any change:

(1) to the license holder's controlling individual as defined in section 245A.02, subdivision 5a;

(2) to license holder information on file with the secretary of state;

(3) in the location of the program or service licensed under this chapter; and

(4) in the federal or state tax identification number associated with the license holder.

(c) When a license holder notifies the commissioner of a change to the business structure governing the licensed program or services but is not selling the business, the license holder must provide amended articles of incorporation and other documentation of the change and any other information requested by the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 4. **[245A.043] LICENSE APPLICATION AFTER CHANGE OF OWNERSHIP.**

Subdivision 1. **Transfer prohibited.** A license issued under this chapter is only valid for a premises and individual, organization, or government entity identified by the commissioner on the license. A license is not transferable or assignable.

Subd. 2. **Change of ownership.** If the commissioner determines that there will be a change of ownership, the commissioner shall require submission of a new license application. A change of ownership occurs when:

(1) the license holder sells or transfers 100 percent of the property, stock, or assets;

(2) the license holder merges with another organization;

(3) the license holder consolidates with two or more organizations, resulting in the creation of a new organization;

(4) there is a change in the federal tax identification number associated with the license holder; or

(5) there is a turnover of each controlling individual associated with the license within a 12-month period. A change to the license holder's controlling individuals, including a change due to a transfer of stock, is not a change of ownership if at least one controlling individual who was listed on the license for at least 12 consecutive months continues to be a controlling individual after the reported change.

Subd. 3. **Change of ownership requirements.** (a) A license holder who intends to change the ownership of the program or service under subdivision 2 to a party that intends to assume operation without an interruption in service longer than 60 days after acquiring the program or service must provide the commissioner with written notice of the proposed sale or change, on a form provided by the commissioner, at least 60 days before the anticipated date of the change in ownership. For purposes of this subdivision and subdivision 4, "party" means the party that intends to operate the service or program.

(b) The party must submit a license application under this chapter on the form and in the manner prescribed by the commissioner at least 30 days before the change of ownership is complete and must include documentation to support the upcoming change. The form and manner of the application prescribed by the commissioner shall require only information which is specifically required by statute or rule. The party must comply with background study requirements under chapter 245C and shall pay the application fee required in section 245A.10. A party that intends to assume operation without an interruption in service longer than 60 days after acquiring the program or service is exempt from the requirements of Minnesota Rules, part 9530.6800.

(c) The commissioner may develop streamlined application procedures when the party is an existing license holder under this chapter and is acquiring a program licensed under this chapter or service in the same service class as one or more licensed programs or services the party operates and those licenses are in substantial compliance according to the licensing standards in this chapter and applicable rules. For purposes of this subdivision, "substantial compliance" means within the past 12 months the commissioner did not: (i) issue a sanction under section 245A.07 against a license held by the party or (ii) make a license held by the party conditional according to section 245A.06.

(d) Except when a temporary change of ownership license is issued pursuant to subdivision 4, the existing license holder is solely responsible for operating the program according to applicable rules and statutes until a license under this chapter is issued to the party.

(e) If a licensing inspection of the program or service was conducted within the previous 12 months and the existing license holder's license record demonstrates substantial compliance with the applicable licensing requirements, the commissioner may waive the party's inspection required by section 245A.04, subdivision 4. The party must submit to the commissioner proof that the premises was inspected by a fire marshal or that the fire marshal deemed that an inspection was not warranted and proof that the premises was inspected for compliance with the building code or that no inspection was deemed warranted.

(f) If the party is seeking a license for a program or service that has an outstanding correction order, the party must submit a letter with the license application identifying how and within what length of time the party shall resolve the outstanding correction order and come into full compliance with the licensing requirements.

(g) Any action taken under section 245A.06 or 245A.07 against the existing license holder's license at the time the party is applying for a license, including when the existing license holder is operating under a conditional license or is subject to a revocation, shall remain in effect until the commissioner determines that the grounds for the action are corrected or no longer exist.

(h) The commissioner shall evaluate the application of the party according to section 245A.04, subdivision 6. Pursuant to section 245A.04, subdivision 7, if the commissioner determines that the party complies with applicable laws and rules, the commissioner may issue a license or a temporary change of ownership license.

(i) The commissioner may deny an application as provided in section 245A.05. An applicant whose application was denied by the commissioner may appeal the denial according to section 245A.05.

(j) This subdivision does not apply to a licensed program or service located in a home where the license holder resides.

Subd. 4. **Temporary change of ownership license.** (a) After receiving the party's application and upon the written request of the existing license holder and the party, the commissioner may issue a temporary change of ownership license to the party while the commissioner evaluates the party's application. Until a decision is made to grant or deny a license under this chapter, the existing license holder and the party shall both be responsible for operating the program or service according to applicable laws and rules, and the sale or transfer of the license holder's ownership interest in the licensed program or service does not terminate the existing license.

(b) The commissioner may establish criteria to issue a temporary change of ownership license, if a license holder's death, divorce, or other event affects the ownership of the program, when an applicant seeks to assume operation of the program or service to ensure continuity of the program or service while a license application is evaluated. This subdivision applies to any program or service licensed under this chapter.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 5. Minnesota Statutes 2018, section 245C.22, subdivision 4, is amended to read:

Subd. 4. **Risk of harm; set aside.** (a) The commissioner may set aside the disqualification if the commissioner finds that the individual has submitted sufficient information to demonstrate that the individual does not pose a risk of harm to any person served by the applicant, license holder, or other entities as provided in this chapter.

(b) In determining whether the individual has met the burden of proof by demonstrating the individual does not pose a risk of harm, the commissioner shall consider:

(1) the nature, severity, and consequences of the event or events that led to the disqualification;

(2) whether there is more than one disqualifying event;

(3) the age and vulnerability of the victim at the time of the event;

(4) the harm suffered by the victim;

(5) vulnerability of persons served by the program;

(6) the similarity between the victim and persons served by the program;

(7) the time elapsed without a repeat of the same or similar event;

(8) documentation of successful completion by the individual studied of training or rehabilitation pertinent to the event; and

(9) any other information relevant to reconsideration.

(c) If the individual requested reconsideration on the basis that the information relied upon to disqualify the individual was incorrect or inaccurate and the commissioner determines that the information relied upon to disqualify the individual is correct, the commissioner must also determine if the individual poses a risk of harm to persons receiving services in accordance with paragraph (b).

(d) For an individual in the substance use disorder field serving persons 18 years of age or older, the commissioner shall set aside the disqualification if the following criteria are met:

(1) the individual submits sufficient documentation to demonstrate that the individual has not committed a crime of violence as listed under section 624.712, subdivision 5, excepting offenses listed under section 152.021, subdivision 2 or 2a; 152.022, subdivision 2; 152.023, subdivision 2; 152.024; or 152.025;

(2) the individual is not disqualified under section 245C.15, subdivision 1, permanent disqualification;

(3) the individual provided documentation of successful completion of treatment, at least one year prior to the date of the request for reconsideration, at a program licensed under chapter 245G;

(4) the individual provided documentation demonstrating abstinence from controlled substances, as defined in section 152.01, subdivision 4, for the period of one year prior to the date of the request for reconsideration; and

(5) the individual is seeking employment in the substance use disorder field, including as direct-care staff providing supportive services or health supervision services in a lodging establishment or board and lodging establishment required to be registered under section 157.17, in which predominately reside individuals being treated for or recovering from a substance use disorder.

Sec. 6. Minnesota Statutes 2018, section 245C.22, subdivision 5, is amended to read:

Subd. 5. **Scope of set-aside.** (a) If the commissioner sets aside a disqualification under this section, the disqualified individual remains disqualified, but may hold a license and have direct contact with or access to persons receiving services. Except as provided in paragraph (b), the commissioner's set-aside of a disqualification is limited solely to the licensed program, applicant, or agency specified in the set aside notice under section 245C.23. For personal care provider organizations, the commissioner's set-aside may further be limited to a specific individual who is receiving services. For new background studies required under section 245C.04, subdivision 1, paragraph (h), if an individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

(b) If the commissioner has previously set aside an individual's disqualification for one or more programs or agencies, and the individual is the subject of a subsequent background study for a different program or agency, the commissioner shall determine whether the disqualification is set aside for the program or agency that initiated the subsequent background study. A notice of a set-aside under paragraph (c) shall be issued within 15 working days if all of the following criteria are met:

(1) the subsequent background study was initiated in connection with a program licensed or regulated under the same provisions of law and rule for at least one program for which the individual's disqualification was previously set aside by the commissioner;

(2) the individual is not disqualified for an offense specified in section 245C.15, subdivision 1 or 2;

(3) the commissioner has received no new information to indicate that the individual may pose a risk of harm to any person served by the program; and

(4) the previous set-aside was not limited to a specific person receiving services.

(c) Notwithstanding paragraph (b), clause (2), or an individual who is employed in the substance use disorder field, if the commissioner has previously set aside an individual's disqualification for one or more programs or agencies, and the individual is the subject of a subsequent background study for a different program or agency, the commissioner shall set aside the disqualification for the program or agency that initiated the subsequent background study when the criteria under paragraph (b), clauses (1), (3), and (4) are met and the individual is not disqualified for an offense specified in section 254C.15, subdivision 1. A notice of a set-aside under paragraph (d) shall be issued within 15 working days.

~~(c)~~ (d) When a disqualification is set aside under paragraph (b), the notice of background study results issued under section 245C.17, in addition to the requirements under section 245C.17, shall state that the disqualification is set aside for the program or agency that initiated the subsequent background study. The notice must inform the individual that the individual may request reconsideration of the disqualification under section 245C.21 on the basis that the information used to disqualify the individual is incorrect.

Sec. 7. Minnesota Statutes 2018, section 254B.03, subdivision 2, is amended to read:

Subd. 2. **Chemical dependency fund payment.** (a) Payment from the chemical dependency fund is limited to payments for services other than detoxification licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, that, if located outside of federally recognized tribal lands, would be required to be licensed by the commissioner as a chemical dependency treatment or rehabilitation program under sections 245A.01 to 245A.16, and services other than detoxification provided in another state that would be required to be licensed as a chemical dependency program if the program were in the state. Out of state vendors must also provide the commissioner with assurances that the program complies substantially with state licensing requirements and possesses all licenses and certifications required by the host state to provide chemical dependency treatment. Vendors receiving

payments from the chemical dependency fund must not require co-payment from a recipient of benefits for services provided under this subdivision. The vendor is prohibited from using the client's public benefits to offset the cost of services paid under this section. The vendor shall not require the client to use public benefits for room or board costs. This includes but is not limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP benefits. Retention of SNAP benefits is a right of a client receiving services through the consolidated chemical dependency treatment fund or through state contracted managed care entities. Payment from the chemical dependency fund shall be made for necessary room and board costs provided by vendors certified according to section 254B.05, or in a community hospital licensed by the commissioner of health according to sections 144.50 to 144.56 to a client who is:

(1) determined to meet the criteria for placement in a residential chemical dependency treatment program according to rules adopted under section 254A.03, subdivision 3; and

(2) concurrently receiving a chemical dependency treatment service in a program licensed by the commissioner and reimbursed by the chemical dependency fund.

(b) A county may, from its own resources, provide chemical dependency services for which state payments are not made. A county may elect to use the same invoice procedures and obtain the same state payment services as are used for chemical dependency services for which state payments are made under this section if county payments are made to the state in advance of state payments to vendors. When a county uses the state system for payment, the commissioner shall make monthly billings to the county using the most recent available information to determine the anticipated services for which payments will be made in the coming month. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.

(c) The commissioner shall coordinate chemical dependency services and determine whether there is a need for any proposed expansion of chemical dependency treatment services. ~~The commissioner shall deny vendor certification to any provider that has not received prior approval from the commissioner for the creation of new programs or the expansion of existing program capacity. The commissioner shall consider the provider's capacity to obtain clients from outside the state based on plans, agreements, and previous utilization history, when determining the need for new treatment services.~~ The commissioner may deny vendor certification to a provider if the commissioner determines that the services currently available in the local area are sufficient to meet local need and that the addition of new services would be detrimental to individuals seeking these services.

Sec. 8. Minnesota Statutes 2018, section 256.045, subdivision 3, is amended to read:

Subd. 3. **State agency hearings.** (a) State agency hearings are available for the following:

(1) any person applying for, receiving or having received public assistance, medical care, or a program of social services granted by the state agency or a county agency or the federal Food Stamp Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid;

(2) any patient or relative aggrieved by an order of the commissioner under section 252.27;

(3) a party aggrieved by a ruling of a prepaid health plan;

(4) except as provided under chapter 245C, any individual or facility determined by a lead investigative agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557;

(5) any person whose claim for foster care payment according to a placement of the child resulting from a child protection assessment under section 626.556 is denied or not acted upon with reasonable promptness, regardless of funding source;

(6) any person to whom a right of appeal according to this section is given by other provision of law;

(7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15;

(8) an applicant aggrieved by an adverse decision to an application or redetermination for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;

(9) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under section 626.556, after the individual or facility has exercised the right to administrative reconsideration under section 626.556;

(10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, following a reconsideration decision issued under section 245C.23, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (9) and a disqualification under this clause in which the

basis for a disqualification is serious or recurring maltreatment, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services judge shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment;

(11) any person with an outstanding debt resulting from receipt of public assistance, medical care, or the federal Food Stamp Act who is contesting a setoff claim by the Department of Human Services or a county agency. The scope of the appeal is the validity of the claimant agency's intention to request a setoff of a refund under chapter 270A against the debt;

(12) a person issued a notice of service termination under section 245D.10, subdivision 3a, from residential supports and services as defined in section 245D.03, subdivision 1, paragraph (c), clause (3), that is not otherwise subject to appeal under subdivision 4a;

(13) an individual disability waiver recipient based on a denial of a request for a rate exception under section 256B.4914; ~~or~~

(14) a person issued a notice of service termination under section 245A.11, subdivision 11, that is not otherwise subject to appeal under subdivision 4a~~.~~; or

(15) a county disputes cost of care under section 246.54 based on administrative or other delay of a client's discharge from a state-operated facility after notification to a county that the client no longer meets medical criteria for the state-operated facility, when the county has developed a viable discharge plan.

(b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or (10), is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under paragraph (a), clauses (4), (9), and (10), is only available when there is no district court action pending. If such action is filed in district court while an administrative review is pending that arises out of some or all of the events or circumstances on which the appeal is based, the administrative review must be suspended

until the judicial actions are completed. If the district court proceedings are completed, dismissed, or overturned, the matter may be considered in an administrative hearing.

(c) For purposes of this section, bargaining unit grievance procedures are not an administrative appeal.

(d) The scope of hearings involving claims to foster care payments under paragraph (a), clause (5), shall be limited to the issue of whether the county is legally responsible for a child's placement under court order or voluntary placement agreement and, if so, the correct amount of foster care payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

(e) The scope of hearings under paragraph (a), clauses (12) and (14), shall be limited to whether the proposed termination of services is authorized under section 245D.10, subdivision 3a, paragraph (b), or 245A.11, subdivision 11, and whether the requirements of section 245D.10, subdivision 3a, paragraphs (c) to (e), or 245A.11, subdivision 2a, paragraphs (d) to (f), were met. If the appeal includes a request for a temporary stay of termination of services, the scope of the hearing shall also include whether the case management provider has finalized arrangements for a residential facility, a program, or services that will meet the assessed needs of the recipient by the effective date of the service termination.

(f) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

(g) An applicant or recipient is not entitled to receive social services beyond the services prescribed under chapter 256M or other social services the person is eligible for under state law.

(h) The commissioner may summarily affirm the county or state agency's proposed action without a hearing when the sole issue is an automatic change due to a change in state or federal law.

(i) Unless federal or Minnesota law specifies a different time frame in which to file an appeal, an individual or organization specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause, as defined in section 256.0451, subdivision

13, why the request was not submitted within the 30-day time limit. The individual filing the appeal has the burden of proving good cause by a preponderance of the evidence.

Sec. 9. **REPEALER.**

Minnesota Rules, parts 9530.6800; and 9530.6810, are repealed.

144A.45 REGULATION OF HOME CARE SERVICES.

Subd. 6. **Home care providers; tuberculosis prevention and control.** (a) A home care provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.

(b) Written compliance with this subdivision must be maintained by the home care provider.

144A.481 HOME CARE LICENSING IMPLEMENTATION FOR NEW LICENSEES AND TRANSITION PERIOD FOR CURRENT LICENSEES.

Subdivision 1. **Temporary home care licenses and changes of ownership.** (a) Beginning January 1, 2014, all temporary license applicants must apply for either a temporary basic or comprehensive home care license.

(b) Temporary home care licenses issued beginning January 1, 2014, shall be issued according to sections 144A.43 to 144A.4798, and the fees in section 144A.472. Temporary licensees must comply with the requirements of this chapter.

(c) No temporary license applications will be accepted nor temporary licenses issued between December 1, 2013, and December 31, 2013.

(d) Beginning October 1, 2013, changes in ownership applications will require payment of the new fees listed in section 144A.472. Providers who are providing nursing, delegated nursing, or professional health care services, must submit the fee for comprehensive home care providers, and all other providers must submit the fee for basic home care providers as provided in section 144A.472. Change of ownership applicants will be issued a new home care license based on the licensure law in effect on June 30, 2013.

Subd. 2. **Current home care licensees with licenses as of December 31, 2013.** (a) Beginning July 1, 2014, department licensed home care providers must apply for either the basic or comprehensive home care license on their regularly scheduled renewal date.

(b) By June 30, 2015, all home care providers must either have a basic or comprehensive home care license or temporary license.

Subd. 3. **Renewal application of home care licensure during transition period.** (a) Renewal and change of ownership applications of home care licenses issued beginning July 1, 2014, will be issued according to sections 144A.43 to 144A.4798 and, upon license renewal or issuance of a new license for a change of ownership, providers must comply with sections 144A.43 to 144A.4798. Prior to renewal, providers must comply with the home care licensure law in effect on June 30, 2013.

(b) The fees charged for licenses renewed between July 1, 2014, and June 30, 2016, shall be the lesser of 200 percent or $1,000, except where the 200 percent or $1,000 increase exceeds the actual renewal fee charged, with a maximum renewal fee of $6,625.

(c) For fiscal year 2014 only, the fees for providers with revenues greater than $25,000 and no more than $100,000 will be $313 and for providers with revenues no more than $25,000 the fee will be $125.

256I.05 MONTHLY RATES.

Subd. 3. **Limits on rates.** When a group residential housing rate is used to pay for an individual's room and board, the rate payable to the residence must not exceed the rate paid by an individual not receiving a group residential housing rate under this chapter.

9530.6800 ASSESSMENT OF NEED FOR TREATMENT PROGRAMS.

Subpart 1. **Assessment of need required for licensure.** Before a license or a provisional license may be issued, the need for the chemical dependency treatment or rehabilitation program must be determined by the commissioner. Need for an additional or expanded chemical dependency treatment program must be determined, in part, based on the recommendation of the county board of commissioners of the county in which the program will be located and the documentation submitted by the applicant at the time of application.

If the county board fails to submit a statement to the commissioner within 60 days of the county board's receipt of the written request from an applicant, as required under part 9530.6810, the commissioner shall determine the need for the applicant's proposed chemical dependency treatment program based on the documentation submitted by the applicant at the time of application.

Subp. 2. **Documentation of need requirements.** An applicant for licensure under parts 9530.2500 to 9530.4000 and Minnesota Statutes, chapter 245G, must submit the documentation in items A and B to the commissioner with the application for licensure:

A. The applicant must submit documentation that it has requested the county board of commissioners of the county in which the chemical dependency treatment program will be located to submit to the commissioner both a written statement that supports or does not support the need for the program and documentation of the rationale used by the county board to make its determination.

B. The applicant must submit a plan for attracting an adequate number of clients to maintain its proposed program capacity, including:

(1) a description of the geographic area to be served;

(2) a description of the target population to be served;

(3) documentation that the capacity or program designs of existing programs are not sufficient to meet the service needs of the chemically abusing or chemically dependent target population if that information is available to the applicant;

(4) a list of referral sources, with an estimation as to the number of clients the referral source will refer to the applicant's program in the first year of operation; and

(5) any other information available to the applicant that supports the need for new or expanded chemical dependency treatment capacity.

9530.6810 COUNTY BOARD RESPONSIBILITY TO REVIEW PROGRAM NEED.

When an applicant for licensure under parts 9530.2500 to 9530.4000 or Minnesota Statutes, chapter 245G, requests a written statement of support for a proposed chemical dependency treatment program from the county board of commissioners of the county in which the proposed program is to be located, the county board, or the county board's designated representative, shall submit a statement to the commissioner that either supports or does not support the need for the applicant's program. The county board's statement must be submitted in accordance with items A and B:

A. the statement must be submitted within 60 days of the county board's receipt of a written request from the applicant for licensure; and

B. the statement must include the rationale used by the county board to make its determination.