

471.7

ARTICLE 30

471.8

COMMUNITY SUPPORTS AND CONTINUING CARE

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

471.11 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license
471.12 for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult
471.13 foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter
471.14 for a physical location that will not be the primary residence of the license holder for the
471.15 entire period of licensure. If a license is issued during this moratorium, and the license
471.16 holder changes the license holder's primary residence away from the physical location of
471.17 the foster care license, the commissioner shall revoke the license according to section
471.18 245A.07. The commissioner shall not issue an initial license for a community residential
471.19 setting licensed under chapter 245D. When approving an exception under this paragraph,
471.20 the commissioner shall consider the resource need determination process in paragraph (h),
471.21 the availability of foster care licensed beds in the geographic area in which the licensee
471.22 seeks to operate, the results of a person's choices during their annual assessment and service
471.23 plan review, and the recommendation of the local county board. The determination by the
471.24 commissioner is final and not subject to appeal. Exceptions to the moratorium include:

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

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

471.30 (3) new foster care licenses or community residential setting licenses determined to be
471.31 needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD,
471.32 or regional treatment center; restructuring of state-operated services that limits the capacity
471.33 of state-operated facilities; or allowing movement to the community for people who no
472.1 longer require the level of care provided in state-operated facilities as provided under section
472.2 256B.092, subdivision 13, or 256B.49, subdivision 24;

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

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

143.19

ARTICLE 5

143.20

COMMUNITY SUPPORTS AND CONTINUING CARE

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

143.23 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license
143.24 for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult
143.25 foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter
143.26 for a physical location that will not be the primary residence of the license holder for the
143.27 entire period of licensure. If a license is issued during this moratorium, and the license
143.28 holder changes the license holder's primary residence away from the physical location of
143.29 the foster care license, the commissioner shall revoke the license according to section
143.30 245A.07. The commissioner shall not issue an initial license for a community residential
143.31 setting licensed under chapter 245D. When approving an exception under this paragraph,
144.1 the commissioner shall consider the resource need determination process in paragraph (h),
144.2 the availability of foster care licensed beds in the geographic area in which the licensee
144.3 seeks to operate, the results of a person's choices during their annual assessment and service
144.4 plan review, and the recommendation of the local county board. The determination by the
144.5 commissioner is final and not subject to appeal. Exceptions to the moratorium include:

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

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

144.11 (3) new foster care licenses or community residential setting licenses determined to be
144.12 needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD,
144.13 or regional treatment center; restructuring of state-operated services that limits the capacity
144.14 of state-operated facilities; or allowing movement to the community for people who no
144.15 longer require the level of care provided in state-operated facilities as provided under section
144.16 256B.092, subdivision 13, or 256B.49, subdivision 24;

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

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

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

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

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

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

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

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

473.1 (8) a vacancy in a setting granted an exception under clause (7), created between January
473.2 1, 2017, and the date of the exception request, by the departure of a person receiving services
473.3 under chapter 245D and residing in the unlicensed setting between January 1, 2017, and
473.4 May 1, 2017. This exception is available when the lead agency provides documentation to
473.5 the commissioner on the eligibility criteria being met. This exception is available until June
473.6 30, 2019.

473.7 (b) The commissioner shall determine the need for newly licensed foster care homes or
473.8 community residential settings as defined under this subdivision. As part of the determination,
473.9 the commissioner shall consider the availability of foster care capacity in the area in which
473.10 the licensee seeks to operate, and the recommendation of the local county board. The

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

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

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

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

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

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

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

145.20 (b) The commissioner shall determine the need for newly licensed foster care homes or
145.21 community residential settings as defined under this subdivision. As part of the determination,
145.22 the commissioner shall consider the availability of foster care capacity in the area in which
145.23 the licensee seeks to operate, and the recommendation of the local county board. The

473.11 determination by the commissioner must be final. A determination of need is not required
473.12 for a change in ownership at the same address.

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

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

473.22 (e) A resource need determination process, managed at the state level, using the available
473.23 reports required by section 144A.351, and other data and information shall be used to
473.24 determine where the reduced capacity determined under section 256B.493 will be
473.25 implemented. The commissioner shall consult with the stakeholders described in section
473.26 144A.351, and employ a variety of methods to improve the state's capacity to meet the
473.27 informed decisions of those people who want to move out of corporate foster care or
473.28 community residential settings, long-term service needs within budgetary limits, including
473.29 seeking proposals from service providers or lead agencies to change service type, capacity,
473.30 or location to improve services, increase the independence of residents, and better meet
473.31 needs identified by the long-term services and supports reports and statewide data and
473.32 information.

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

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

145.24 determination by the commissioner must be final. A determination of need is not required
145.25 for a change in ownership at the same address.

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

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

146.1 (e) A resource need determination process, managed at the state level, using the available
146.2 reports required by section 144A.351, and other data and information shall be used to
146.3 determine where the reduced capacity determined under section 256B.493 will be
146.4 implemented. The commissioner shall consult with the stakeholders described in section
146.5 144A.351, and employ a variety of methods to improve the state's capacity to meet the
146.6 informed decisions of those people who want to move out of corporate foster care or
146.7 community residential settings, long-term service needs within budgetary limits, including
146.8 seeking proposals from service providers or lead agencies to change service type, capacity,
146.9 or location to improve services, increase the independence of residents, and better meet
146.10 needs identified by the long-term services and supports reports and statewide data and
146.11 information.

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

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

474.13 (h) The commissioner may adjust capacity to address needs identified in section
474.14 144A.351. Under this authority, the commissioner may approve new licensed settings or
474.15 delicense existing settings. Delicensing of settings will be accomplished through a process
474.16 identified in section 256B.493. Annually, by August 1, the commissioner shall provide
474.17 information and data on capacity of licensed long-term services and supports, actions taken
474.18 under the subdivision to manage statewide long-term services and supports resources, and
474.19 any recommendations for change to the legislative committees with jurisdiction over the
474.20 health and human services budget.

474.21 (i) The commissioner must notify a license holder when its corporate foster care or
474.22 community residential setting licensed beds are reduced under this section. The notice of
474.23 reduction of licensed beds must be in writing and delivered to the license holder by certified
474.24 mail or personal service. The notice must state why the licensed beds are reduced and must
474.25 inform the license holder of its right to request reconsideration by the commissioner. The
474.26 license holder's request for reconsideration must be in writing. If mailed, the request for
474.27 reconsideration must be postmarked and sent to the commissioner within 20 calendar days
474.28 after the license holder's receipt of the notice of reduction of licensed beds. If a request for
474.29 reconsideration is made by personal service, it must be received by the commissioner within
474.30 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

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

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

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

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

146.26 (h) The commissioner may adjust capacity to address needs identified in section
146.27 144A.351. Under this authority, the commissioner may approve new licensed settings or
146.28 delicense existing settings. Delicensing of settings will be accomplished through a process
146.29 identified in section 256B.493. Annually, by August 1, the commissioner shall provide
146.30 information and data on capacity of licensed long-term services and supports, actions taken
146.31 under the subdivision to manage statewide long-term services and supports resources, and
146.32 any recommendations for change to the legislative committees with jurisdiction over the
146.33 health and human services budget.

146.34 (i) The commissioner must notify a license holder when its corporate foster care or
146.35 community residential setting licensed beds are reduced under this section. The notice of
147.1 reduction of licensed beds must be in writing and delivered to the license holder by certified
147.2 mail or personal service. The notice must state why the licensed beds are reduced and must
147.3 inform the license holder of its right to request reconsideration by the commissioner. The
147.4 license holder's request for reconsideration must be in writing. If mailed, the request for
147.5 reconsideration must be postmarked and sent to the commissioner within 20 calendar days
147.6 after the license holder's receipt of the notice of reduction of licensed beds. If a request for
147.7 reconsideration is made by personal service, it must be received by the commissioner within
147.8 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

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

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

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

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

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

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

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

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

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

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

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

476.13 (f) The commissioner may issue an adult foster care or community residential setting
476.14 license with a capacity of five adults if the fifth bed does not increase the overall statewide

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

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

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

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

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

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

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

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

148.23 (f) The commissioner may issue an adult foster care or community residential setting
148.24 license with a capacity of five adults if the fifth bed does not increase the overall statewide

476.15 capacity of licensed adult foster care or community residential setting beds in homes that
476.16 are not the primary residence of the license holder, as identified in a plan submitted to the
476.17 commissioner by the county, when the capacity is recommended by the county licensing
476.18 agency of the county in which the facility is located and if the recommendation verifies
476.19 that:

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

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

476.23 (i) individualized plan of care;

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

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

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

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

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

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

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

477.12 (b) Basic support services provide the level of assistance, supervision, and care that is
477.13 necessary to ensure the health and welfare of the person and do not include services that

148.25 capacity of licensed adult foster care or community residential setting beds in homes that
148.26 are not the primary residence of the license holder, as identified in a plan submitted to the
148.27 commissioner by the county, when the capacity is recommended by the county licensing
148.28 agency of the county in which the facility is located and if the recommendation verifies
148.29 that:

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

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

148.33 (i) individualized plan of care;

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

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

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

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

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

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

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

149.20 (b) Basic support services provide the level of assistance, supervision, and care that is
149.21 necessary to ensure the health and welfare of the person and do not include services that

477.14 are specifically directed toward the training, treatment, habilitation, or rehabilitation of the
477.15 person. Basic support services include:

477.16 (1) in-home and out-of-home respite care services as defined in section 245A.02,
477.17 subdivision 15, and under the brain injury, community alternative care, community access
477.18 for disability inclusion, developmental ~~disability~~ disabilities, and elderly waiver plans,
477.19 excluding out-of-home respite care provided to children in a family child foster care home
477.20 licensed under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care
477.21 license holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7,
477.22 and 8, or successor provisions; and section 245D.061 or successor provisions, which must
477.23 be stipulated in the statement of intended use required under Minnesota Rules, part
477.24 2960.3000, subpart 4;

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

477.30 (3) personal support as defined under the developmental ~~disability~~ disabilities waiver
477.31 plan;

478.1 (4) 24-hour emergency assistance, personal emergency response as defined under the
478.2 community access for disability inclusion and developmental ~~disability~~ disabilities waiver
478.3 plans;

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

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

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

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

478.15 (1) intervention services, including:

149.22 are specifically directed toward the training, treatment, habilitation, or rehabilitation of the
149.23 person. Basic support services include:

149.24 (1) in-home and out-of-home respite care services as defined in section 245A.02,
149.25 subdivision 15, and under the brain injury, community alternative care, community access
149.26 for disability inclusion, developmental ~~disability~~ disabilities, and elderly waiver plans,
149.27 excluding out-of-home respite care provided to children in a family child foster care home
149.28 licensed under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care
149.29 license holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7,
149.30 and 8, or successor provisions; and section 245D.061 or successor provisions, which must
149.31 be stipulated in the statement of intended use required under Minnesota Rules, part
149.32 2960.3000, subpart 4;

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

150.6 (3) personal support as defined under the developmental ~~disability~~ disabilities waiver
150.7 plan;

150.8 (4) 24-hour emergency assistance, personal emergency response as defined under the
150.9 community access for disability inclusion and developmental ~~disability~~ disabilities waiver
150.10 plans;

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

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

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

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

150.22 (1) intervention services, including:

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

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

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

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

478.26 (i) in-home family support and supported living services as defined under the
478.27 developmental ~~disability disabilities~~ waiver plan;

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

478.30 (iii) semi-independent living services; and

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

479.1 (3) residential supports and services, including:

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

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

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

479.11 (4) day services, including:

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

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

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

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

151.1 (i) in-home family support and supported living services as defined under the
151.2 developmental ~~disability disabilities~~ waiver plan;

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

151.5 (iii) semi-independent living services; and

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

151.8 (3) residential supports and services, including:

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

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

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

151.18 (4) day services, including:

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

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

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

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

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

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

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

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

480.10 (b) At least once per year, the license holder, in coordination with the person's support
480.11 team or expanded support team, must meet with the person, the person's legal representative,
480.12 and the case manager to discuss how technology might be used to meet the person's desired
480.13 outcomes. The coordinated service and support plan or support plan addendum must include
480.14 a summary of this discussion. The summary must include a statement regarding any decision

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

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

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

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

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

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

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

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

152.20 (b) At least once per year, the license holder, in coordination with the person's support
152.21 team or expanded support team, must meet with the person, the person's legal representative,
152.22 and the case manager to discuss how technology might be used to meet the person's desired
152.23 outcomes. The coordinated service and support plan or support plan addendum must include
152.24 a summary of this discussion. The summary must include a statement regarding any decision

480.15 made related to the use of technology and a description of any further research that must
480.16 be completed before a decision regarding the use of technology can be made. Nothing in
480.17 this paragraph requires the coordinated service and support plan to include the use of
480.18 technology for the provision of services.

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

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

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

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

481.6 Subd. 2. ~~Behavior Positive support professional qualifications.~~ A behavior positive
481.7 support professional providing behavioral positive support services as identified in section
481.8 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the
481.9 following areas as required under the brain injury and, community access for disability
481.10 inclusion, community alternative care, and developmental disabilities waiver plans or
481.11 successor plans:

481.12 (1) ethical considerations;

481.13 (2) functional assessment;

152.25 made related to the use of technology and a description of any further research that must
152.26 be completed before a decision regarding the use of technology can be made. Nothing in
152.27 this paragraph requires the coordinated service and support plan to include the use of
152.28 technology for the provision of services.

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

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

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

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

153.18 Subd. 2. ~~Behavior Positive support professional qualifications.~~ A behavior positive
153.19 support professional providing behavioral positive support services as identified in section
153.20 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the
153.21 following areas as required under the brain injury and, community access for disability
153.22 inclusion, community alternative care, and developmental disabilities waiver plans or
153.23 successor plans:

153.24 (1) ethical considerations;

153.25 (2) functional assessment;

- 481.14 (3) functional analysis;
- 481.15 (4) measurement of behavior and interpretation of data;
- 481.16 (5) selecting intervention outcomes and strategies;
- 481.17 (6) behavior reduction and elimination strategies that promote least restrictive approved
481.18 alternatives;
- 481.19 (7) data collection;
- 481.20 (8) staff and caregiver training;
- 481.21 (9) support plan monitoring;
- 481.22 (10) co-occurring mental disorders or neurocognitive disorder;
- 481.23 (11) demonstrated expertise with populations being served; and
- 481.24 (12) must be a:
- 481.25 (i) psychologist licensed under sections 148.88 to 148.98, who has stated to the Board
481.26 of Psychology competencies in the above identified areas;
- 481.27 (ii) clinical social worker licensed as an independent clinical social worker under chapter
481.28 148D, or a person with a master's degree in social work from an accredited college or
481.29 university, with at least 4,000 hours of post-master's supervised experience in the delivery
481.30 of clinical services in the areas identified in clauses (1) to (11);
- 482.1 (iii) physician licensed under chapter 147 and certified by the American Board of
482.2 Psychiatry and Neurology or eligible for board certification in psychiatry with competencies
482.3 in the areas identified in clauses (1) to (11);
- 482.4 (iv) licensed professional clinical counselor licensed under sections 148B.29 to 148B.39
482.5 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical
482.6 services who has demonstrated competencies in the areas identified in clauses (1) to (11);
- 482.7 (v) person with a master's degree from an accredited college or university in one of the
482.8 behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised

- 153.26 (3) functional analysis;
- 153.27 (4) measurement of behavior and interpretation of data;
- 153.28 (5) selecting intervention outcomes and strategies;
- 153.29 (6) behavior reduction and elimination strategies that promote least restrictive approved
153.30 alternatives;
- 153.31 (7) data collection;
- 153.32 (8) staff and caregiver training;
- 154.1 (9) support plan monitoring;
- 154.2 (10) co-occurring mental disorders or neurocognitive disorder;
- 154.3 (11) demonstrated expertise with populations being served; and
- 154.4 (12) must be a:
- 154.5 (i) psychologist licensed under sections 148.88 to 148.98, who has stated to the Board
154.6 of Psychology competencies in the above identified areas;
- 154.7 (ii) clinical social worker licensed as an independent clinical social worker under chapter
154.8 148D, or a person with a master's degree in social work from an accredited college or
154.9 university, with at least 4,000 hours of post-master's supervised experience in the delivery
154.10 of clinical services in the areas identified in clauses (1) to (11);
- 154.11 (iii) physician licensed under chapter 147 and certified by the American Board of
154.12 Psychiatry and Neurology or eligible for board certification in psychiatry with competencies
154.13 in the areas identified in clauses (1) to (11);
- 154.14 (iv) licensed professional clinical counselor licensed under sections 148B.29 to 148B.39
154.15 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical
154.16 services who has demonstrated competencies in the areas identified in clauses (1) to (11);
- 154.17 (v) person with a master's degree from an accredited college or university in one of the
154.18 behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised

482.9 experience in the delivery of clinical services with demonstrated competencies in the areas
482.10 identified in clauses (1) to (11); ~~or~~

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

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

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

482.20 Subd. 3. **Behavior Positive support analyst qualifications.** (a) A ~~behavior~~ positive
482.21 support analyst providing behavioral positive support services as identified in section
482.22 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the
482.23 following areas as required under the brain injury ~~and~~ community access for disability
482.24 inclusion, community alternative care, and developmental disabilities waiver plans or
482.25 successor plans:

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

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

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

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

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

154.19 experience in the delivery of clinical services with demonstrated competencies in the areas
154.20 identified in clauses (1) to (11); ~~or~~

154.21 (vi) person with a master's degree or PhD in one of the behavioral sciences or related
154.22 fields with demonstrated expertise in positive support services, as determined by the person's
154.23 case manager based on the person's needs as outlined in the person's community support
154.24 plan; or

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

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

155.2 Subd. 3. **Behavior Positive support analyst qualifications.** (a) A ~~behavior~~ positive
155.3 support analyst providing behavioral positive support services as identified in section
155.4 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the
155.5 following areas as required under the brain injury ~~and~~ community access for disability
155.6 inclusion, community alternative care, and developmental disabilities waiver plans or
155.7 successor plans:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

483.22 ~~(6) (3) be determined by a behavior positive support professional to have the training~~
483.23 ~~and prerequisite skills required to provide positive practice strategies as well as behavior~~
483.24 ~~reduction approved and permitted intervention to the person who receives behavioral positive~~
483.25 ~~support; and~~

483.26 ~~(7) (4) be under the direct supervision of a behavior positive support professional.~~

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

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

483.30 Subd. 4. **Behavior Positive support specialist qualifications.** (a) A behavior positive
483.31 support specialist providing behavioral positive support services as identified in section
484.1 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the
484.2 following areas as required under the brain injury and community access for disability

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

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

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

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

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

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

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

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

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

156.5 ~~(6) (3) be determined by a behavior positive support professional to have the training~~
156.6 ~~and prerequisite skills required to provide positive practice strategies as well as behavior~~
156.7 ~~reduction approved and permitted intervention to the person who receives behavioral positive~~
156.8 ~~support; and~~

156.9 ~~(7) (4) be under the direct supervision of a behavior positive support professional.~~

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

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

156.13 Subd. 4. **Behavior Positive support specialist qualifications.** (a) A behavior positive
156.14 support specialist providing behavioral positive support services as identified in section
156.15 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the
156.16 following areas as required under the brain injury and community access for disability

484.3 inclusion, community alternative care, and developmental disabilities waiver plans or
484.4 successor plans:

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

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

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

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

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

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

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

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

484.16 ~~(4) (2) be determined by a behavior positive support professional to have the training~~
484.17 ~~and prerequisite skills required to provide positive practices strategies as well as behavior~~
484.18 ~~reduction approved intervention to the person who receives behavioral positive support;~~
484.19 ~~and~~

484.20 ~~(5) (3) be under the direct supervision of a behavior positive support professional.~~

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

156.17 inclusion, community alternative care, and developmental disabilities waiver plans or
156.18 successor plans:

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

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

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

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

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

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

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

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

156.30 ~~(4) (2) be determined by a behavior positive support professional to have the training~~
156.31 ~~and prerequisite skills required to provide positive practices strategies as well as behavior~~
157.1 ~~reduction approved intervention to the person who receives behavioral positive support;~~
157.2 ~~and~~

157.3 ~~(5) (3) be under the direct supervision of a behavior positive support professional.~~

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

157.6 Sec. 8. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision
157.7 to read:

157.8 Subd. 65. Prescribed pediatric extended care center services. Medical assistance
157.9 covers prescribed pediatric extended care center basic services as defined under section
157.10 144H.01, subdivision 2. The commissioner shall set two payment rates for basic services
157.11 provided at prescribed pediatric extended care centers licensed under chapter 144H: (1) a
157.12 \$250 half-day rate per child attending a prescribed pediatric extended care center for less
157.13 than four hours per day; and (2) a \$500 full-day rate per child attending a prescribed pediatric

157.14 extended care center for four hours or more per day. The rates established in this subdivision
157.15 may be reevaluated by the commissioner two years after the effective date of this subdivision.

157.16 **EFFECTIVE DATE.** This section is effective January 1, 2019, or upon federal approval,
157.17 whichever occurs later. The commissioner of human services shall notify the revisor of
157.18 statutes when federal approval is obtained.

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

484.24 Subd. 3a. **Assessment; defined.** (a) "Assessment" means a review and evaluation of a
484.25 recipient's need for personal care assistance services conducted in person. Assessments for
484.26 personal care assistance services shall be conducted by the county public health nurse or a
484.27 certified public health nurse under contract with the county except when a long-term care
484.28 consultation assessment is being conducted for the purposes of determining a person's
484.29 eligibility for home and community-based waiver services including personal care assistance
484.30 services according to section 256B.0911. During the transition to MnCHOICES, a certified
484.31 assessor may complete the assessment defined in this subdivision. An in-person assessment
485.1 must include: documentation of health status, determination of need, evaluation of service
485.2 effectiveness, identification of appropriate services, service plan development or modification,
485.3 coordination of services, referrals and follow-up to appropriate payers and community
485.4 resources, completion of required reports, recommendation of service authorization, and
485.5 consumer education. Once the need for personal care assistance services is determined under
485.6 this section, the county public health nurse or certified public health nurse under contract
485.7 with the county is responsible for communicating this recommendation to the commissioner
485.8 and the recipient. An in-person assessment must occur at least annually or when there is a
485.9 significant change in the recipient's condition or when there is a change in the need for
485.10 personal care assistance services. A service update may substitute for the annual face-to-face
485.11 assessment when there is not a significant change in recipient condition or a change in the
485.12 need for personal care assistance service. A service update may be completed by telephone,
485.13 used when there is no need for an increase in personal care assistance services, and used
485.14 for two consecutive assessments if followed by a face-to-face assessment. A service update
485.15 must be completed on a form approved by the commissioner. A service update or review
485.16 for temporary increase includes a review of initial baseline data, evaluation of service
485.17 effectiveness, redetermination of service need, modification of service plan and appropriate
485.18 referrals, update of initial forms, obtaining service authorization, and on going consumer
485.19 education. Assessments or reassessments must be completed on forms provided by the
485.20 commissioner within 30 days of a request for home care services by a recipient or responsible
485.21 party.

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

485.24 Sec. 9. Minnesota Statutes 2016, section 256B.0659, subdivision 11, is amended to read:

157.19 Sec. 9. Minnesota Statutes 2016, section 256B.0659, subdivision 11, is amended to read:

485.25 Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must
485.26 meet the following requirements:

485.27 (1) be at least 18 years of age with the exception of persons who are 16 or 17 years of
485.28 age with these additional requirements:

485.29 (i) supervision by a qualified professional every 60 days; and

485.30 (ii) employment by only one personal care assistance provider agency responsible for
485.31 compliance with current labor laws;

485.32 (2) be employed by a personal care assistance provider agency;

486.1 (3) enroll with the department as a personal care assistant after clearing a background
486.2 study. Except as provided in subdivision 11a, before a personal care assistant provides
486.3 services, the personal care assistance provider agency must initiate a background study on
486.4 the personal care assistant under chapter 245C, and the personal care assistance provider
486.5 agency must have received a notice from the commissioner that the personal care assistant
486.6 is:

486.7 (i) not disqualified under section 245C.14; or

486.8 (ii) is disqualified, but the personal care assistant has received a set aside of the
486.9 disqualification under section 245C.22;

486.10 (4) be able to effectively communicate with the recipient and personal care assistance
486.11 provider agency;

486.12 (5) be able to provide covered personal care assistance services according to the recipient's
486.13 personal care assistance care plan, respond appropriately to recipient needs, and report
486.14 changes in the recipient's condition to the supervising qualified professional or physician;

486.15 (6) not be a consumer of personal care assistance services;

486.16 (7) maintain daily written records including, but not limited to, time sheets under
486.17 subdivision 12;

486.18 (8) effective January 1, 2010, complete standardized training as determined by the
486.19 commissioner before completing enrollment. The training must be available in languages
486.20 other than English and to those who need accommodations due to disabilities. Personal care
486.21 assistant training must include successful completion of the following training components:
486.22 basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic

157.20 Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must
157.21 meet the following requirements:

157.22 (1) be at least 18 years of age with the exception of persons who are 16 or 17 years of
157.23 age with these additional requirements:

157.24 (i) supervision by a qualified professional every 60 days; and

157.25 (ii) employment by only one personal care assistance provider agency responsible for
157.26 compliance with current labor laws;

157.27 (2) be employed by a personal care assistance provider agency;

157.28 (3) enroll with the department as a personal care assistant after clearing a background
157.29 study. Except as provided in subdivision 11a, before a personal care assistant provides
157.30 services, the personal care assistance provider agency must initiate a background study on
157.31 the personal care assistant under chapter 245C, and the personal care assistance provider
158.1 agency must have received a notice from the commissioner that the personal care assistant
158.2 is:

158.3 (i) not disqualified under section 245C.14; or

158.4 (ii) is disqualified, but the personal care assistant has received a set aside of the
158.5 disqualification under section 245C.22;

158.6 (4) be able to effectively communicate with the recipient and personal care assistance
158.7 provider agency;

158.8 (5) be able to provide covered personal care assistance services according to the recipient's
158.9 personal care assistance care plan, respond appropriately to recipient needs, and report
158.10 changes in the recipient's condition to the supervising qualified professional or physician;

158.11 (6) not be a consumer of personal care assistance services;

158.12 (7) maintain daily written records including, but not limited to, time sheets under
158.13 subdivision 12;

158.14 (8) effective January 1, 2010, complete standardized training as determined by the
158.15 commissioner before completing enrollment. The training must be available in languages
158.16 other than English and to those who need accommodations due to disabilities. Personal care
158.17 assistant training must include successful completion of the following training components:
158.18 basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic

486.23 roles and responsibilities of personal care assistants including information about assistance
486.24 with lifting and transfers for recipients, emergency preparedness, orientation to positive
486.25 behavioral practices, fraud issues, and completion of time sheets. Upon completion of the
486.26 training components, the personal care assistant must demonstrate the competency to provide
486.27 assistance to recipients;

486.28 (9) complete training and orientation on the needs of the recipient; and

486.29 (10) be limited to providing and being paid for up to 275 hours per month of personal
486.30 care assistance services regardless of the number of recipients being served or the number
486.31 of personal care assistance provider agencies enrolled with. The number of hours worked
486.32 per day shall not be disallowed by the department unless in violation of the law.

487.1 (b) A legal guardian may be a personal care assistant if the guardian is not being paid
487.2 for the guardian services and meets the criteria for personal care assistants in paragraph (a).

487.3 (c) Persons who do not qualify as a personal care assistant include parents, stepparents,
487.4 and legal guardians of minors; spouses; paid legal guardians of adults; family foster care
487.5 providers, except as otherwise allowed in section 256B.0625, subdivision 19a; and staff of
487.6 a residential setting.

487.7 (d) Personal care services qualify for the enhanced rate described in subdivision 17a if
487.8 the personal care assistant providing the services:

487.9 (1) provides services, according to the care plan in subdivision 7, to a recipient who
487.10 qualifies for 12 or more hours per day of PCA services; and

487.11 (2) satisfies the current requirements of Medicare for training and competency or
487.12 competency evaluation of home health aides or nursing assistants, as provided in the Code
487.13 of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state approved
487.14 training or competency requirements.

487.15 **EFFECTIVE DATE.** This section is effective July 1, 2018.

487.16 Sec. 10. Minnesota Statutes 2016, section 256B.0659, is amended by adding a subdivision
487.17 to read:

487.18 Subd. 17a. **Enhanced rate.** An enhanced rate of 105 percent of the rate paid for PCA
487.19 services shall be paid for services provided to persons who qualify for 12 or more hours of
487.20 PCA service per day when provided by a PCA who meets the requirements of subdivision
487.21 11, paragraph (d). The enhanced rate for PCA services includes, and is not in addition to,
487.22 any rate adjustments implemented by the commissioner on July 1, 2018, to comply with

158.19 roles and responsibilities of personal care assistants including information about assistance
158.20 with lifting and transfers for recipients, emergency preparedness, orientation to positive
158.21 behavioral practices, fraud issues, and completion of time sheets. Upon completion of the
158.22 training components, the personal care assistant must demonstrate the competency to provide
158.23 assistance to recipients;

158.24 (9) complete training and orientation on the needs of the recipient; and

158.25 (10) be limited to providing and being paid for up to 275 hours per month of personal
158.26 care assistance services regardless of the number of recipients being served or the number
158.27 of personal care assistance provider agencies enrolled with. The number of hours worked
158.28 per day shall not be disallowed by the department unless in violation of the law.

158.29 (b) A legal guardian may be a personal care assistant if the guardian is not being paid
158.30 for the guardian services and meets the criteria for personal care assistants in paragraph (a).

158.31 (c) Persons who do not qualify as a personal care assistant include parents, stepparents,
158.32 and legal guardians of minors; spouses; paid legal guardians of adults; family foster care
159.1 providers, except as otherwise allowed in section 256B.0625, subdivision 19a; and staff of
159.2 a residential setting.

159.3 (d) Personal care services qualify for the enhanced rate described in subdivision 17a if
159.4 the personal care assistant providing the services:

159.5 (1) provides services, according to the care plan in subdivision 7, to a recipient who
159.6 qualifies for 12 or more hours per day of PCA services; and

159.7 (2) satisfies the current requirements of Medicare for training and competency or
159.8 competency evaluation of home health aides or nursing assistants, as provided in the Code
159.9 of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state approved
159.10 training or competency requirements.

159.11 **EFFECTIVE DATE.** This section is effective July 1, 2018.

159.12 Sec. 10. Minnesota Statutes 2016, section 256B.0659, is amended by adding a subdivision
159.13 to read:

159.14 Subd. 17a. **Enhanced rate.** An enhanced rate of 105 percent of the rate paid for PCA
159.15 services shall be paid for services provided to persons who qualify for 12 or more hours of
159.16 PCA service per day when provided by a PCA who meets the requirements of subdivision
159.17 11, paragraph (d). The enhanced rate for PCA services includes, and is not in addition to,
159.18 any rate adjustments implemented by the commissioner on July 1, 2018, to comply with

487.23 the terms of a collective bargaining agreement between the state of Minnesota and an
487.24 exclusive representative of individual providers under section 179A.54 that provides for
487.25 wage increases for individual providers who serve participants assessed to need 12 or more
487.26 hours of PCA services per day.

487.27 **EFFECTIVE DATE.** This section is effective July 1, 2018.

487.28 Sec. 11. Minnesota Statutes 2016, section 256B.0659, subdivision 21, is amended to read:

487.29 Subd. 21. **Requirements for provider enrollment of personal care assistance provider**
487.30 **agencies.** (a) All personal care assistance provider agencies must provide, at the time of
487.31 enrollment, reenrollment, and revalidation as a personal care assistance provider agency in
488.1 a format determined by the commissioner, information and documentation that includes,
488.2 but is not limited to, the following:

488.3 (1) the personal care assistance provider agency's current contact information including
488.4 address, telephone number, and e-mail address;

488.5 (2) proof of surety bond coverage. Upon new enrollment, or if the provider's Medicaid
488.6 revenue in the previous calendar year is up to and including \$300,000, the provider agency
488.7 must purchase a surety bond of \$50,000. If the Medicaid revenue in the previous year is
488.8 over \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety
488.9 bond must be in a form approved by the commissioner, must be renewed annually, and must
488.10 allow for recovery of costs and fees in pursuing a claim on the bond;

488.11 (3) proof of fidelity bond coverage in the amount of \$20,000;

488.12 (4) proof of workers' compensation insurance coverage;

488.13 (5) proof of liability insurance;

488.14 (6) a description of the personal care assistance provider agency's organization identifying
488.15 the names of all owners, managing employees, staff, board of directors, and the affiliations
488.16 of the directors, owners, or staff to other service providers;

488.17 (7) a copy of the personal care assistance provider agency's written policies and
488.18 procedures including: hiring of employees; training requirements; service delivery; and
488.19 employee and consumer safety including process for notification and resolution of consumer
488.20 grievances, identification and prevention of communicable diseases, and employee
488.21 misconduct;

159.19 the terms of a collective bargaining agreement between the state of Minnesota and an
159.20 exclusive representative of individual providers under section 179A.54 that provides for
159.21 wage increases for individual providers who serve participants assessed to need 12 or more
159.22 hours of PCA services per day.

159.23 **EFFECTIVE DATE.** This section is effective July 1, 2018.

159.24 Sec. 11. Minnesota Statutes 2016, section 256B.0659, subdivision 21, is amended to read:

159.25 Subd. 21. **Requirements for provider enrollment of personal care assistance provider**
159.26 **agencies.** (a) All personal care assistance provider agencies must provide, at the time of
159.27 enrollment, reenrollment, and revalidation as a personal care assistance provider agency in
159.28 a format determined by the commissioner, information and documentation that includes,
159.29 but is not limited to, the following:

159.30 (1) the personal care assistance provider agency's current contact information including
159.31 address, telephone number, and e-mail address;

160.1 (2) proof of surety bond coverage. Upon new enrollment, or if the provider's Medicaid
160.2 revenue in the previous calendar year is up to and including \$300,000, the provider agency
160.3 must purchase a surety bond of \$50,000. If the Medicaid revenue in the previous year is
160.4 over \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety
160.5 bond must be in a form approved by the commissioner, must be renewed annually, and must
160.6 allow for recovery of costs and fees in pursuing a claim on the bond;

160.7 (3) proof of fidelity bond coverage in the amount of \$20,000;

160.8 (4) proof of workers' compensation insurance coverage;

160.9 (5) proof of liability insurance;

160.10 (6) a description of the personal care assistance provider agency's organization identifying
160.11 the names of all owners, managing employees, staff, board of directors, and the affiliations
160.12 of the directors, owners, or staff to other service providers;

160.13 (7) a copy of the personal care assistance provider agency's written policies and
160.14 procedures including: hiring of employees; training requirements; service delivery; and
160.15 employee and consumer safety including process for notification and resolution of consumer
160.16 grievances, identification and prevention of communicable diseases, and employee
160.17 misconduct;

488.22 (8) copies of all other forms the personal care assistance provider agency uses in the
488.23 course of daily business including, but not limited to:

488.24 (i) a copy of the personal care assistance provider agency's time sheet if the time sheet
488.25 varies from the standard time sheet for personal care assistance services approved by the
488.26 commissioner, and a letter requesting approval of the personal care assistance provider
488.27 agency's nonstandard time sheet;

488.28 (ii) the personal care assistance provider agency's template for the personal care assistance
488.29 care plan; and

488.30 (iii) the personal care assistance provider agency's template for the written agreement
488.31 in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

489.1 (9) a list of all training and classes that the personal care assistance provider agency
489.2 requires of its staff providing personal care assistance services;

489.3 (10) documentation that the personal care assistance provider agency and staff have
489.4 successfully completed all the training required by this section, including the requirements
489.5 under subdivision 11, paragraph (d), if enhanced PCA services are provided and submitted
489.6 for an enhanced rate under subdivision 17a;

489.7 (11) documentation of the agency's marketing practices;

489.8 (12) disclosure of ownership, leasing, or management of all residential properties that
489.9 is used or could be used for providing home care services;

489.10 (13) documentation that the agency will use the following percentages of revenue
489.11 generated from the medical assistance rate paid for personal care assistance services for
489.12 employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal
489.13 care assistance choice option and 72.5 percent of revenue from other personal care assistance
489.14 providers. The revenue generated by the qualified professional and the reasonable costs
489.15 associated with the qualified professional shall not be used in making this calculation; and

489.16 (14) effective May 15, 2010, documentation that the agency does not burden recipients'
489.17 free exercise of their right to choose service providers by requiring personal care assistants
489.18 to sign an agreement not to work with any particular personal care assistance recipient or
489.19 for another personal care assistance provider agency after leaving the agency and that the
489.20 agency is not taking action on any such agreements or requirements regardless of the date
489.21 signed.

160.18 (8) copies of all other forms the personal care assistance provider agency uses in the
160.19 course of daily business including, but not limited to:

160.20 (i) a copy of the personal care assistance provider agency's time sheet if the time sheet
160.21 varies from the standard time sheet for personal care assistance services approved by the
160.22 commissioner, and a letter requesting approval of the personal care assistance provider
160.23 agency's nonstandard time sheet;

160.24 (ii) the personal care assistance provider agency's template for the personal care assistance
160.25 care plan; and

160.26 (iii) the personal care assistance provider agency's template for the written agreement
160.27 in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

160.28 (9) a list of all training and classes that the personal care assistance provider agency
160.29 requires of its staff providing personal care assistance services;

160.30 (10) documentation that the personal care assistance provider agency and staff have
160.31 successfully completed all the training required by this section, including the requirements
161.1 under subdivision 11, paragraph (d), if enhanced PCA services are provided and submitted
161.2 for an enhanced rate under subdivision 17a;

161.3 (11) documentation of the agency's marketing practices;

161.4 (12) disclosure of ownership, leasing, or management of all residential properties that
161.5 is used or could be used for providing home care services;

161.6 (13) documentation that the agency will use the following percentages of revenue
161.7 generated from the medical assistance rate paid for personal care assistance services for
161.8 employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal
161.9 care assistance choice option and 72.5 percent of revenue from other personal care assistance
161.10 providers. The revenue generated by the qualified professional and the reasonable costs
161.11 associated with the qualified professional shall not be used in making this calculation; and

161.12 (14) effective May 15, 2010, documentation that the agency does not burden recipients'
161.13 free exercise of their right to choose service providers by requiring personal care assistants
161.14 to sign an agreement not to work with any particular personal care assistance recipient or
161.15 for another personal care assistance provider agency after leaving the agency and that the
161.16 agency is not taking action on any such agreements or requirements regardless of the date
161.17 signed.

489.22 (b) Personal care assistance provider agencies shall provide the information specified
489.23 in paragraph (a) to the commissioner at the time the personal care assistance provider agency
489.24 enrolls as a vendor or upon request from the commissioner. The commissioner shall collect
489.25 the information specified in paragraph (a) from all personal care assistance providers
489.26 beginning July 1, 2009.

489.27 (c) All personal care assistance provider agencies shall require all employees in
489.28 management and supervisory positions and owners of the agency who are active in the
489.29 day-to-day management and operations of the agency to complete mandatory training as
489.30 determined by the commissioner before enrollment of the agency as a provider. Employees
489.31 in management and supervisory positions and owners who are active in the day-to-day
489.32 operations of an agency who have completed the required training as an employee with a
489.33 personal care assistance provider agency do not need to repeat the required training if they
489.34 are hired by another agency, if they have completed the training within the past three years.
490.1 By September 1, 2010, the required training must be available with meaningful access
490.2 according to title VI of the Civil Rights Act and federal regulations adopted under that law
490.3 or any guidance from the United States Health and Human Services Department. The
490.4 required training must be available online or by electronic remote connection. The required
490.5 training must provide for competency testing. Personal care assistance provider agency
490.6 billing staff shall complete training about personal care assistance program financial
490.7 management. This training is effective July 1, 2009. Any personal care assistance provider
490.8 agency enrolled before that date shall, if it has not already, complete the provider training
490.9 within 18 months of July 1, 2009. Any new owners or employees in management and
490.10 supervisory positions involved in the day-to-day operations are required to complete
490.11 mandatory training as a requisite of working for the agency. Personal care assistance provider
490.12 agencies certified for participation in Medicare as home health agencies are exempt from
490.13 the training required in this subdivision. When available, Medicare-certified home health
490.14 agency owners, supervisors, or managers must successfully complete the competency test.

490.15 **EFFECTIVE DATE.** This section is effective July 1, 2018.

490.16 Sec. 12. Minnesota Statutes 2016, section 256B.0659, subdivision 24, is amended to read:

490.17 Subd. 24. **Personal care assistance provider agency; general duties.** A personal care
490.18 assistance provider agency shall:

490.19 (1) enroll as a Medicaid provider meeting all provider standards, including completion
490.20 of the required provider training;

490.21 (2) comply with general medical assistance coverage requirements;

161.18 (b) Personal care assistance provider agencies shall provide the information specified
161.19 in paragraph (a) to the commissioner at the time the personal care assistance provider agency
161.20 enrolls as a vendor or upon request from the commissioner. The commissioner shall collect
161.21 the information specified in paragraph (a) from all personal care assistance providers
161.22 beginning July 1, 2009.

161.23 (c) All personal care assistance provider agencies shall require all employees in
161.24 management and supervisory positions and owners of the agency who are active in the
161.25 day-to-day management and operations of the agency to complete mandatory training as
161.26 determined by the commissioner before enrollment of the agency as a provider. Employees
161.27 in management and supervisory positions and owners who are active in the day-to-day
161.28 operations of an agency who have completed the required training as an employee with a
161.29 personal care assistance provider agency do not need to repeat the required training if they
161.30 are hired by another agency, if they have completed the training within the past three years.
161.31 By September 1, 2010, the required training must be available with meaningful access
161.32 according to title VI of the Civil Rights Act and federal regulations adopted under that law
161.33 or any guidance from the United States Health and Human Services Department. The
161.34 required training must be available online or by electronic remote connection. The required
162.1 training must provide for competency testing. Personal care assistance provider agency
162.2 billing staff shall complete training about personal care assistance program financial
162.3 management. This training is effective July 1, 2009. Any personal care assistance provider
162.4 agency enrolled before that date shall, if it has not already, complete the provider training
162.5 within 18 months of July 1, 2009. Any new owners or employees in management and
162.6 supervisory positions involved in the day-to-day operations are required to complete
162.7 mandatory training as a requisite of working for the agency. Personal care assistance provider
162.8 agencies certified for participation in Medicare as home health agencies are exempt from
162.9 the training required in this subdivision. When available, Medicare-certified home health
162.10 agency owners, supervisors, or managers must successfully complete the competency test.

162.11 **EFFECTIVE DATE.** This section is effective July 1, 2018.

162.12 Sec. 12. Minnesota Statutes 2016, section 256B.0659, subdivision 24, is amended to read:

162.13 Subd. 24. **Personal care assistance provider agency; general duties.** A personal care
162.14 assistance provider agency shall:

162.15 (1) enroll as a Medicaid provider meeting all provider standards, including completion
162.16 of the required provider training;

162.17 (2) comply with general medical assistance coverage requirements;

490.22 (3) demonstrate compliance with law and policies of the personal care assistance program
490.23 to be determined by the commissioner;

490.24 (4) comply with background study requirements;

490.25 (5) verify and keep records of hours worked by the personal care assistant and qualified
490.26 professional;

490.27 (6) not engage in any agency-initiated direct contact or marketing in person, by phone,
490.28 or other electronic means to potential recipients, guardians, or family members;

490.29 (7) pay the personal care assistant and qualified professional based on actual hours of
490.30 services provided;

490.31 (8) withhold and pay all applicable federal and state taxes;

491.1 (9) ~~effective January 1, 2010~~, document that the agency uses a minimum of 72.5 percent
491.2 of the revenue generated by the medical assistance rate for personal care assistance services
491.3 for employee personal care assistant wages and benefits. The revenue generated by the
491.4 qualified professional and the reasonable costs associated with the qualified professional
491.5 shall not be used in making this calculation;

491.6 (10) make the arrangements and pay unemployment insurance, taxes, workers'
491.7 compensation, liability insurance, and other benefits, if any;

491.8 (11) enter into a written agreement under subdivision 20 before services are provided;

491.9 (12) report suspected neglect and abuse to the common entry point according to section
491.10 256B.0651;

491.11 (13) provide the recipient with a copy of the home care bill of rights at start of service;
491.12 ~~and~~

491.13 (14) request reassessments at least 60 days prior to the end of the current authorization
491.14 for personal care assistance services, on forms provided by the commissioner; and

491.15 (15) document that the agency uses the additional revenue due to the enhanced rate under
491.16 subdivision 17a for the wages and benefits of the PCAs whose services meet the requirements
491.17 under subdivision 11, paragraph (d).

162.18 (3) demonstrate compliance with law and policies of the personal care assistance program
162.19 to be determined by the commissioner;

162.20 (4) comply with background study requirements;

162.21 (5) verify and keep records of hours worked by the personal care assistant and qualified
162.22 professional;

162.23 (6) not engage in any agency-initiated direct contact or marketing in person, by phone,
162.24 or other electronic means to potential recipients, guardians, or family members;

162.25 (7) pay the personal care assistant and qualified professional based on actual hours of
162.26 services provided;

162.27 (8) withhold and pay all applicable federal and state taxes;

162.28 (9) ~~effective January 1, 2010~~, document that the agency uses a minimum of 72.5 percent
162.29 of the revenue generated by the medical assistance rate for personal care assistance services
162.30 for employee personal care assistant wages and benefits. The revenue generated by the
162.31 qualified professional and the reasonable costs associated with the qualified professional
162.32 shall not be used in making this calculation;

163.1 (10) make the arrangements and pay unemployment insurance, taxes, workers'
163.2 compensation, liability insurance, and other benefits, if any;

163.3 (11) enter into a written agreement under subdivision 20 before services are provided;

163.4 (12) report suspected neglect and abuse to the common entry point according to section
163.5 256B.0651;

163.6 (13) provide the recipient with a copy of the home care bill of rights at start of service;
163.7 ~~and~~

163.8 (14) request reassessments at least 60 days prior to the end of the current authorization
163.9 for personal care assistance services, on forms provided by the commissioner; and

163.10 (15) document that the agency uses the additional revenue due to the enhanced rate under
163.11 subdivision 17a for the wages and benefits of the PCAs whose services meet the requirements
163.12 under subdivision 11, paragraph (d).

491.18 **EFFECTIVE DATE.** This section is effective July 1, 2018.

491.19 Sec. 13. Minnesota Statutes 2016, section 256B.0659, subdivision 28, is amended to read:

491.20 Subd. 28. **Personal care assistance provider agency; required documentation.** (a)
491.21 Required documentation must be completed and kept in the personal care assistance provider
491.22 agency file or the recipient's home residence. The required documentation consists of:

491.23 (1) employee files, including:

491.24 (i) applications for employment;

491.25 (ii) background study requests and results;

491.26 (iii) orientation records about the agency policies;

491.27 (iv) trainings completed with demonstration of competence, including verification of
491.28 the completion of training required under subdivision 11, paragraph (d), for any billing of
491.29 the enhanced rate under subdivision 17a;

491.30 (v) supervisory visits;

492.1 (vi) evaluations of employment; and

492.2 (vii) signature on fraud statement;

492.3 (2) recipient files, including:

492.4 (i) demographics;

492.5 (ii) emergency contact information and emergency backup plan;

492.6 (iii) personal care assistance service plan;

492.7 (iv) personal care assistance care plan;

492.8 (v) month-to-month service use plan;

492.9 (vi) all communication records;

492.10 (vii) start of service information, including the written agreement with recipient; and

163.13 **EFFECTIVE DATE.** This section is effective July 1, 2018.

163.14 Sec. 13. Minnesota Statutes 2016, section 256B.0659, subdivision 28, is amended to read:

163.15 Subd. 28. **Personal care assistance provider agency; required documentation.** (a)
163.16 Required documentation must be completed and kept in the personal care assistance provider
163.17 agency file or the recipient's home residence. The required documentation consists of:

163.18 (1) employee files, including:

163.19 (i) applications for employment;

163.20 (ii) background study requests and results;

163.21 (iii) orientation records about the agency policies;

163.22 (iv) trainings completed with demonstration of competence, including verification of
163.23 the completion of training required under subdivision 11, paragraph (d), for any billing of
163.24 the enhanced rate under subdivision 17a;

163.25 (v) supervisory visits;

163.26 (vi) evaluations of employment; and

163.27 (vii) signature on fraud statement;

163.28 (2) recipient files, including:

163.29 (i) demographics;

164.1 (ii) emergency contact information and emergency backup plan;

164.2 (iii) personal care assistance service plan;

164.3 (iv) personal care assistance care plan;

164.4 (v) month-to-month service use plan;

164.5 (vi) all communication records;

164.6 (vii) start of service information, including the written agreement with recipient; and

492.11 (viii) date the home care bill of rights was given to the recipient;

492.12 (3) agency policy manual, including:

492.13 (i) policies for employment and termination;

492.14 (ii) grievance policies with resolution of consumer grievances;

492.15 (iii) staff and consumer safety;

492.16 (iv) staff misconduct; and

492.17 (v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and

492.18 resolution of consumer grievances;

492.19 (4) time sheets for each personal care assistant along with completed activity sheets for

492.20 each recipient served; and

492.21 (5) agency marketing and advertising materials and documentation of marketing activities

492.22 and costs.

492.23 (b) The commissioner may assess a fine of up to \$500 on provider agencies that do not

492.24 consistently comply with the requirements of this subdivision.

492.25 **EFFECTIVE DATE.** This section is effective July 1, 2018.

492.26 Sec. 14. Minnesota Statutes 2017 Supplement, section 256B.0911, subdivision 1a, is

492.27 **amended to read:**

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

493.1 (a) **Until additional requirements apply under paragraph (b), "long-term care consultation**

493.2 **services" means:**

493.3 (1) **intake for and access to assistance in identifying services needed to maintain an**

493.4 **individual in the most inclusive environment;**

493.5 (2) **providing recommendations for and referrals to cost-effective community services**

493.6 **that are available to the individual;**

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

164.7 (viii) date the home care bill of rights was given to the recipient;

164.8 (3) agency policy manual, including:

164.9 (i) policies for employment and termination;

164.10 (ii) grievance policies with resolution of consumer grievances;

164.11 (iii) staff and consumer safety;

164.12 (iv) staff misconduct; and

164.13 (v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and

164.14 resolution of consumer grievances;

164.15 (4) time sheets for each personal care assistant along with completed activity sheets for

164.16 each recipient served; and

164.17 (5) agency marketing and advertising materials and documentation of marketing activities

164.18 and costs.

164.19 (b) The commissioner may assess a fine of up to \$500 on provider agencies that do not

164.20 consistently comply with the requirements of this subdivision.

164.21 **EFFECTIVE DATE.** This section is effective July 1, 2018.

- 493.8 (4) providing information regarding eligibility for Minnesota health care programs;
- 493.9 (5) face-to-face long-term care consultation assessments, which may be completed in a
493.10 hospital, nursing facility, intermediate care facility for persons with developmental disabilities
493.11 (ICF/DDs), regional treatment centers, or the person's current or planned residence;
- 493.12 (6) determination of home and community-based waiver and other service eligibility as
493.13 required under sections 256B.0913, 256B.0915, and 256B.49, including level of care
493.14 determination for individuals who need an institutional level of care as determined under
493.15 subdivision 4e, based on assessment and community support plan development, appropriate
493.16 referrals to obtain necessary diagnostic information, and including an eligibility determination
493.17 for consumer-directed community supports;
- 493.18 (7) providing recommendations for institutional placement when there are no
493.19 cost-effective community services available;
- 493.20 (8) providing access to assistance to transition people back to community settings after
493.21 institutional admission; and
- 493.22 (9) providing information about competitive employment, with or without supports, for
493.23 school-age youth and working-age adults and referrals to the Disability Linkage Line and
493.24 Disability Benefits 101 to ensure that an informed choice about competitive employment
493.25 can be made. For the purposes of this subdivision, "competitive employment" means work
493.26 in the competitive labor market that is performed on a full-time or part-time basis in an
493.27 integrated setting, and for which an individual is compensated at or above the minimum
493.28 wage, but not less than the customary wage and level of benefits paid by the employer for
493.29 the same or similar work performed by individuals without disabilities.
- 493.30 (b) Upon statewide implementation of lead agency requirements in subdivisions 2b, 2c,
493.31 and 3a, "long-term care consultation services" also means:
- 493.32 (1) service eligibility determination for state plan home care services identified in:
- 494.1 (i) section 256B.0625, subdivisions 7, 19a; and 19c;
- 494.2 (ii) consumer support grants under section 256.476; or
- 494.3 (iii) section 256B.85;
- 494.4 (2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,
494.5 determination of eligibility for case management services available under sections 256B.0621,
494.6 subdivision 2, paragraph clause (4), and 256B.0924 and Minnesota Rules, part 9525.0016;

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

494.12 (4) obtaining necessary diagnostic information to determine eligibility under clauses (2)
494.13 and (3); and

494.14 (5) notwithstanding Minnesota Rules, parts 9525.0004 to 9525.0024, initial eligibility
494.15 determination for case management services available under Minnesota Rules, part
494.16 9525.0016.

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

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

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

494.26 (f) "Person-centered planning" is a process that includes the active participation of a
494.27 person in the planning of the person's services, including in making meaningful and informed
494.28 choices about the person's own goals, talents, and objectives, as well as making meaningful
494.29 and informed choices about the services the person receives. For the purposes of this section,
494.30 "informed choice" means a voluntary choice of services by a person from all available
494.31 service options based on accurate and complete information concerning all available service
494.32 options and concerning the person's own preferences, abilities, goals, and objectives. In
495.1 order for a person to make an informed choice, all available options must be developed and
495.2 presented to the person to empower the person to make decisions.

495.3 Sec. 15. Minnesota Statutes 2017 Supplement, section 256B.0911, subdivision 3a, is
495.4 amended to read:

495.5 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services
495.6 planning, or other assistance intended to support community-based living, including persons
495.7 who need assessment in order to determine waiver or alternative care program eligibility,
495.8 must be visited by a long-term care consultation team within 20 calendar days after the date

495.9 on which an assessment was requested or recommended. Upon statewide implementation
495.10 of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person
495.11 requesting personal care assistance services and home care nursing. The commissioner shall
495.12 provide at least a 90-day notice to lead agencies prior to the effective date of this requirement.
495.13 Face-to-face assessments must be conducted according to paragraphs (b) to (i).

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

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

495.22 (d) The assessment must be conducted in a face-to-face conversational interview with
495.23 the person being assessed and. The person's legal representative must provide input during
495.24 the assessment process and may do so remotely if requested. At the request of the person,
495.25 other individuals may participate in the assessment to provide information on the needs,
495.26 strengths, and preferences of the person necessary to develop a community support plan
495.27 that ensures the person's health and safety. Except for legal representatives or family members
495.28 invited by the person, persons participating in the assessment may not be a provider of
495.29 service or have any financial interest in the provision of services. For persons who are to
495.30 be assessed for elderly waiver customized living or adult day services under section
495.31 256B.0915, with the permission of the person being assessed or the person's designated or
495.32 legal representative, the client's current or proposed provider of services may submit a copy
495.33 of the provider's nursing assessment or written report outlining its recommendations regarding
495.34 the client's care needs. The person conducting the assessment must notify the provider of
496.1 the date by which this information is to be submitted. This information shall be provided
496.2 to the person conducting the assessment prior to the assessment. For a person who is to be
496.3 assessed for waiver services under section 256B.092 or 256B.49, with the permission of
496.4 the person being assessed or the person's designated legal representative, the person's current
496.5 provider of services may submit a written report outlining recommendations regarding the
496.6 person's care needs prepared by a direct service employee with at least 20 hours of service
496.7 to that client. The person conducting the assessment or reassessment must notify the provider
496.8 of the date by which this information is to be submitted. This information shall be provided
496.9 to the person conducting the assessment and the person or the person's legal representative,
496.10 and must be considered prior to the finalization of the assessment or reassessment.

496.11 (e) The person or the person's legal representative must be provided with a written
496.12 community support plan within 40 calendar days of the assessment visit the timelines
496.13 established by the commissioner, regardless of whether the individual is eligible for

- 496.14 Minnesota health care programs. The timeline for completing the community support plan
496.15 and any required coordinated service and support plan must not exceed 56 calendar days
496.16 from the assessment visit.
- 496.17 (f) For a person being assessed for elderly waiver services under section 256B.0915, a
496.18 provider who submitted information under paragraph (d) shall receive the final written
496.19 community support plan when available and the Residential Services Workbook.
- 496.20 (g) The written community support plan must include:
- 496.21 (1) a summary of assessed needs as defined in paragraphs (c) and (d);
- 496.22 (2) the individual's options and choices to meet identified needs, including all available
496.23 options for case management services and providers, including service provided in a
496.24 non-disability-specific setting;
- 496.25 (3) identification of health and safety risks and how those risks will be addressed,
496.26 including personal risk management strategies;
- 496.27 (4) referral information; and
- 496.28 (5) informal caregiver supports, if applicable.
- 496.29 For a person determined eligible for state plan home care under subdivision 1a, paragraph
496.30 (b), clause (1), the person or person's representative must also receive a copy of the home
496.31 care service plan developed by the certified assessor.
- 496.32 (h) A person may request assistance in identifying community supports without
496.33 participating in a complete assessment. Upon a request for assistance identifying community
497.1 support, the person must be transferred or referred to long-term care options counseling
497.2 services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for
497.3 telephone assistance and follow up.
- 497.4 (i) The person has the right to make the final decision between institutional placement
497.5 and community placement after the recommendations have been provided, except as provided
497.6 in section 256.975, subdivision 7a, paragraph (d).
- 497.7 (j) The lead agency must give the person receiving assessment or support planning, or
497.8 the person's legal representative, materials, and forms supplied by the commissioner
497.9 containing the following information:

- 497.10 (1) written recommendations for community-based services and consumer-directed
497.11 options;
- 497.12 (2) documentation that the most cost-effective alternatives available were offered to the
497.13 individual. For purposes of this clause, "cost-effective" means community services and
497.14 living arrangements that cost the same as or less than institutional care. For an individual
497.15 found to meet eligibility criteria for home and community-based service programs under
497.16 section 256B.0915 or 256B.49, "cost-effectiveness" has the meaning found in the federally
497.17 approved waiver plan for each program;
- 497.18 (3) the need for and purpose of preadmission screening conducted by long-term care
497.19 options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects
497.20 nursing facility placement. If the individual selects nursing facility placement, the lead
497.21 agency shall forward information needed to complete the level of care determinations and
497.22 screening for developmental disability and mental illness collected during the assessment
497.23 to the long-term care options counselor using forms provided by the commissioner;
- 497.24 (4) the role of long-term care consultation assessment and support planning in eligibility
497.25 determination for waiver and alternative care programs, and state plan home care, case
497.26 management, and other services as defined in subdivision 1a, paragraphs (a), clause (6),
497.27 and (b);
- 497.28 (5) information about Minnesota health care programs;
- 497.29 (6) the person's freedom to accept or reject the recommendations of the team;
- 497.30 (7) the person's right to confidentiality under the Minnesota Government Data Practices
497.31 Act, chapter 13;
- 497.32 (8) the certified assessor's decision regarding the person's need for institutional level of
497.33 care as determined under criteria established in subdivision 4e and the certified assessor's
498.1 decision regarding eligibility for all services and programs as defined in subdivision 1a,
498.2 paragraphs (a), clause (6), and (b); and
- 498.3 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
498.4 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
498.5 (8), and (b), and incorporating the decision regarding the need for institutional level of care
498.6 or the lead agency's final decisions regarding public programs eligibility according to section
498.7 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right
498.8 to the person and must visually point out where in the document the right to appeal is stated.

498.9 (k) Face-to-face assessment completed as part of eligibility determination for the
498.10 alternative care, elderly waiver, developmental disabilities, community access for disability
498.11 inclusion, community alternative care, and brain injury waiver programs under sections
498.12 256B.0913, 256B.0915, 256B.092, and 256B.49 is valid to establish service eligibility for
498.13 no more than 60 calendar days after the date of assessment.

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

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

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

499.1 Sec. 16. Minnesota Statutes 2017 Supplement, section 256B.0911, subdivision 3f, is
499.2 amended to read:

499.3 Subd. 3f. **Long-term care reassessments and community support plan updates.** (a)
499.4 Prior to a face-to-face reassessment, the certified assessor must review the person's most
499.5 recent assessment. Reassessments must be tailored using the professional judgment of the
499.6 assessor to the person's known needs, strengths, preferences, and circumstances.
499.7 Reassessments provide information to support the person's informed choice and opportunities
499.8 to express choice regarding activities that contribute to quality of life, as well as information
499.9 and opportunity to identify goals related to desired employment, community activities, and
499.10 preferred living environment. Reassessments ~~allow for~~ require a review of the most recent
499.11 assessment, review of the current coordinated service and support plan's effectiveness,
499.12 monitoring of services, and the development of an updated person-centered community
499.13 support plan. Reassessments verify continued eligibility or offer alternatives as warranted
499.14 and provide an opportunity for quality assurance of service delivery. Face-to-face ~~assessments,~~
499.15 reassessments must be conducted annually or as required by federal and state laws and rules.

499.16 For reassessments, the certified assessor and the individual responsible for developing the
499.17 coordinated service and support plan must ensure the continuity of care for the person
499.18 receiving services and complete the updated community support plan and the updated
499.19 coordinated service and support plan within the timelines established by the commissioner.

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

499.23 Sec. 17. Minnesota Statutes 2017 Supplement, section 256B.0911, subdivision 5, is
499.24 amended to read:

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

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

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

500.9 Sec. 18. Minnesota Statutes 2016, section 256B.0915, subdivision 6, is amended to read:

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

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

- 500.17 under section 256B.0911, subdivision 3a, and the coordinated service and support plan must
500.18 not exceed 56 calendar days from the assessment visit;
- 500.19 (2) includes the person's need for service and identification of service needs that will be
500.20 or that are met by the person's relatives, friends, and others, as well as community services
500.21 used by the general public;
- 500.22 (3) reasonably ensures the health and welfare of the recipient;
- 500.23 (4) identifies the person's preferences for services as stated by the person or the person's
500.24 legal guardian or conservator;
- 500.25 (5) reflects the person's informed choice between institutional and community-based
500.26 services, as well as choice of services, supports, and providers, including available case
500.27 manager providers;
- 500.28 (6) identifies long-range and short-range goals for the person;
- 500.29 (7) identifies specific services and the amount, frequency, duration, and cost of the
500.30 services to be provided to the person based on assessed needs, preferences, and available
500.31 resources;
- 500.32 (8) includes information about the right to appeal decisions under section 256.045; and
- 501.1 (9) includes the authorized annual and estimated monthly amounts for the services.
- 501.2 (b) In developing the coordinated service and support plan, the case manager should
501.3 also include the use of volunteers, religious organizations, social clubs, and civic and service
501.4 organizations to support the individual in the community. The lead agency must be held
501.5 harmless for damages or injuries sustained through the use of volunteers and agencies under
501.6 this paragraph, including workers' compensation liability.
- 501.7 Sec. 19. Minnesota Statutes 2016, section 256B.092, subdivision 1b, is amended to read:
- 501.8 Subd. 1b. **Coordinated service and support plan.** (a) Each recipient of home and
501.9 community-based waived services shall be provided a copy of the written coordinated
501.10 service and support plan ~~which~~ that:
- 501.11 (1) is developed with and signed by the recipient within ~~ten working days after the case~~
501.12 manager receives the assessment information and written community support plan as
501.13 described in section 256B.0911, subdivision 3a, from the certified assessor the timelines
501.14 established by the commissioner. The timeline for completing the community support plan

- 501.15 under section 256B.0911, subdivision 3a, and the coordinated service and support plan must
501.16 not exceed 56 calendar days from the assessment visit;
- 501.17 (2) includes the person's need for service, including identification of service needs that
501.18 will be or that are met by the person's relatives, friends, and others, as well as community
501.19 services used by the general public;
- 501.20 (3) reasonably ensures the health and welfare of the recipient;
- 501.21 (4) identifies the person's preferences for services as stated by the person, the person's
501.22 legal guardian or conservator, or the parent if the person is a minor, including the person's
501.23 choices made on self-directed options and on services and supports to achieve employment
501.24 goals;
- 501.25 (5) provides for an informed choice, as defined in section 256B.77, subdivision 2,
501.26 paragraph (o), of service and support providers, and identifies all available options for case
501.27 management services and providers;
- 501.28 (6) identifies long-range and short-range goals for the person;
- 501.29 (7) identifies specific services and the amount and frequency of the services to be provided
501.30 to the person based on assessed needs, preferences, and available resources. The coordinated
501.31 service and support plan shall also specify other services the person needs that are not
501.32 available;
- 502.1 (8) identifies the need for an individual program plan to be developed by the provider
502.2 according to the respective state and federal licensing and certification standards, and
502.3 additional assessments to be completed or arranged by the provider after service initiation;
- 502.4 (9) identifies provider responsibilities to implement and make recommendations for
502.5 modification to the coordinated service and support plan;
- 502.6 (10) includes notice of the right to request a conciliation conference or a hearing under
502.7 section 256.045;
- 502.8 (11) is agreed upon and signed by the person, the person's legal guardian or conservator,
502.9 or the parent if the person is a minor, and the authorized county representative;
- 502.10 (12) is reviewed by a health professional if the person has overriding medical needs that
502.11 impact the delivery of services; and
- 502.12 (13) includes the authorized annual and monthly amounts for the services.

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

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

502.20 Sec. 20. Minnesota Statutes 2016, section 256B.092, subdivision 1g, is amended to read:

502.21 Subd. 1g. **Conditions not requiring development of coordinated service and support**
502.22 **plan.** (a) Unless otherwise required by federal law, the county agency is not required to
502.23 complete a coordinated service and support plan as defined in subdivision 1b for:

502.24 (1) persons whose families are requesting respite care for their family member who
502.25 resides with them, or whose families are requesting a family support grant and are not
502.26 requesting purchase or arrangement of habilitative services; and

502.27 (2) persons with developmental disabilities, living independently without authorized
502.28 services or receiving funding for services at a rehabilitation facility as defined in section
502.29 268A.01, subdivision 6, and not in need of or requesting additional services.

502.30 (b) Unless otherwise required by federal law, the county agency is not required to conduct
502.31 or arrange for an annual needs reassessment by a certified assessor. The case manager who
502.32 works on behalf of the person to identify the person's needs and to minimize the impact of
503.1 the disability on the person's life must develop a person-centered service plan based on the
503.2 person's assessed needs and preferences. The person-centered service plan must be reviewed
503.3 annually. This paragraph applies to persons with developmental disabilities who are receiving
503.4 case management services under Minnesota Rules, part 9525.0036, and who make an
503.5 informed choice to decline an assessment under section 256B.0911.

164.22 Sec. 14. Minnesota Statutes 2017 Supplement, section 256B.0921, is amended to read:

164.23 **256B.0921 HOME AND COMMUNITY-BASED SERVICES INCENTIVE**
164.24 **INNOVATION POOL.**

164.25 The commissioner of human services shall develop an initiative to provide incentives
164.26 for innovation in: (1) achieving integrated competitive employment; (2) achieving integrated
164.27 competitive employment for youth under age 25 upon their graduation from school; (3)
164.28 living in the most integrated setting; and (4) other outcomes determined by the commissioner.

165.1 The commissioner shall seek requests for proposals and shall contract with one or more
165.2 entities to provide incentive payments for meeting identified outcomes.

503.6 Sec. 21. Minnesota Statutes 2016, section 256B.093, subdivision 1, is amended to read:

503.7 Subdivision 1. **State traumatic brain injury program.** (a) The commissioner of human
503.8 services shall:

503.9 (1) maintain a statewide traumatic brain injury program;

503.10 (2) supervise and coordinate services and policies for persons with traumatic brain
503.11 injuries;

503.12 (3) contract with qualified agencies or employ staff to provide statewide administrative
503.13 case management and consultation;

503.14 (4) maintain an advisory committee to provide recommendations in reports to the
503.15 commissioner regarding program and service needs of persons with brain injuries;

503.16 (5) investigate the need for the development of rules or statutes for the brain injury home
503.17 and community-based services waiver; and

503.18 (6) investigate present and potential models of service coordination which can be
503.19 delivered at the local level; and

503.20 ~~(7)~~ (b) The advisory committee required by paragraph (a), clause (4), must consist of
503.21 no fewer than ten members and no more than 30 members. The commissioner shall appoint
503.22 all advisory committee members to one- or two-year terms and appoint one member as
503.23 chair. The advisory committee ~~does not terminate until~~ expires on June 30, ~~2018~~ 2023.

503.24 Sec. 22. Minnesota Statutes 2017 Supplement, section 256B.49, subdivision 13, is amended
503.25 to read:

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

503.29 (1) finalizing the written coordinated service and support plan within ~~ten working days~~
503.30 ~~after the case manager receives the plan from the certified assessor~~ the timelines established
503.31 by the commissioner. The timeline for completing the community support plan under section
504.1 256B.0911, subdivision 3a, and the coordinated service and support plan must not exceed
504.2 56 calendar days from the assessment visit;

- 504.3 (2) informing the recipient or the recipient's legal guardian or conservator of service
504.4 options;
- 504.5 (3) assisting the recipient in the identification of potential service providers and available
504.6 options for case management service and providers, including services provided in a
504.7 non-disability-specific setting;
- 504.8 (4) assisting the recipient to access services and assisting with appeals under section
504.9 256.045; and
- 504.10 (5) coordinating, evaluating, and monitoring of the services identified in the service
504.11 plan.
- 504.12 (b) The case manager may delegate certain aspects of the case management service
504.13 activities to another individual provided there is oversight by the case manager. The case
504.14 manager may not delegate those aspects which require professional judgment including:
- 504.15 (1) finalizing the coordinated service and support plan;
- 504.16 (2) ongoing assessment and monitoring of the person's needs and adequacy of the
504.17 approved coordinated service and support plan; and
- 504.18 (3) adjustments to the coordinated service and support plan.
- 504.19 (c) Case management services must be provided by a public or private agency that is
504.20 enrolled as a medical assistance provider determined by the commissioner to meet all of
504.21 the requirements in the approved federal waiver plans. Case management services must not
504.22 be provided to a recipient by a private agency that has any financial interest in the provision
504.23 of any other services included in the recipient's coordinated service and support plan. For
504.24 purposes of this section, "private agency" means any agency that is not identified as a lead
504.25 agency under section 256B.0911, subdivision 1a, paragraph (e).
- 504.26 (d) For persons who need a positive support transition plan as required in chapter 245D,
504.27 the case manager shall participate in the development and ongoing evaluation of the plan
504.28 with the expanded support team. At least quarterly, the case manager, in consultation with
504.29 the expanded support team, shall evaluate the effectiveness of the plan based on progress
504.30 evaluation data submitted by the licensed provider to the case manager. The evaluation must
504.31 identify whether the plan has been developed and implemented in a manner to achieve the
504.32 following within the required timelines:
- 505.1 (1) phasing out the use of prohibited procedures;

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

505.4 ~~(3) accomplishment of identified outcomes.~~

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

505.8 Sec. 23. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 2, is
505.9 amended to read:

505.10 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the
505.11 meanings given them, unless the context clearly indicates otherwise.

505.12 (b) "Commissioner" means the commissioner of human services.

505.13 (c) "Component value" means underlying factors that are part of the cost of providing
505.14 services that are built into the waiver rates methodology to calculate service rates.

505.15 (d) "Customized living tool" means a methodology for setting service rates that delineates
505.16 and documents the amount of each component service included in a recipient's customized
505.17 living service plan.

505.18 (e) "Direct care staff" means employees providing direct service provision to people
505.19 receiving services under this section. Direct care staff does not include executive, managerial,
505.20 and administrative staff.

505.21 (f) "Disability waiver rates system" means a statewide system that establishes rates that
505.22 are based on uniform processes and captures the individualized nature of waiver services
505.23 and recipient needs.

505.24 ~~(f) (g)~~ "Individual staffing" means the time spent as a one-to-one interaction specific to
505.25 an individual recipient by staff to provide direct support and assistance with activities of
505.26 daily living, instrumental activities of daily living, and training to participants, and is based
505.27 on the requirements in each individual's coordinated service and support plan under section
505.28 245D.02, subdivision 4b; any coordinated service and support plan addendum under section
505.29 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's
505.30 needs must also be considered.

505.31 ~~(g) (h)~~ "Lead agency" means a county, partnership of counties, or tribal agency charged
505.32 with administering waived services under sections 256B.092 and 256B.49.

165.3 Sec. 15. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 2, is
165.4 amended to read:

165.5 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the
165.6 meanings given them, unless the context clearly indicates otherwise.

165.7 (b) "Commissioner" means the commissioner of human services.

165.8 (c) "Component value" means underlying factors that are part of the cost of providing
165.9 services that are built into the waiver rates methodology to calculate service rates.

165.10 (d) "Customized living tool" means a methodology for setting service rates that delineates
165.11 and documents the amount of each component service included in a recipient's customized
165.12 living service plan.

165.13 (e) "Direct care staff" means employees providing direct service provision to people
165.14 receiving services under this section. Direct care staff does not include executive, managerial,
165.15 and administrative staff.

165.16 (f) "Disability waiver rates system" means a statewide system that establishes rates that
165.17 are based on uniform processes and captures the individualized nature of waiver services
165.18 and recipient needs.

165.19 ~~(f) (g)~~ "Individual staffing" means the time spent as a one-to-one interaction specific to
165.20 an individual recipient by staff to provide direct support and assistance with activities of
165.21 daily living, instrumental activities of daily living, and training to participants, and is based
165.22 on the requirements in each individual's coordinated service and support plan under section
165.23 245D.02, subdivision 4b; any coordinated service and support plan addendum under section
165.24 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's
165.25 needs must also be considered.

165.26 ~~(g) (h)~~ "Lead agency" means a county, partnership of counties, or tribal agency charged
165.27 with administering waived services under sections 256B.092 and 256B.49.

506.1 ~~(h)~~ (i) "Median" means the amount that divides distribution into two equal groups,
506.2 one-half above the median and one-half below the median.

506.3 ~~(h)~~ (j) "Payment or rate" means reimbursement to an eligible provider for services
506.4 provided to a qualified individual based on an approved service authorization.

506.5 ~~(j)~~ (k) "Rates management system" means a Web-based software application that uses
506.6 a framework and component values, as determined by the commissioner, to establish service
506.7 rates.

506.8 ~~(k)~~ (l) "Recipient" means a person receiving home and community-based services funded
506.9 under any of the disability waivers.

506.10 ~~(k)~~ (m) "Shared staffing" means time spent by employees, not defined under paragraph
506.11 ~~(g)~~ (g), providing or available to provide more than one individual with direct support and
506.12 assistance with activities of daily living as defined under section 256B.0659, subdivision
506.13 1, paragraph (b); instrumental activities of daily living as defined under section 256B.0659,
506.14 subdivision 1, paragraph (i); ancillary activities needed to support individual services; and
506.15 training to participants, and is based on the requirements in each individual's coordinated
506.16 service and support plan under section 245D.02, subdivision 4b; any coordinated service
506.17 and support plan addendum under section 245D.02, subdivision 4c; an assessment tool; and
506.18 provider observation of an individual's service need. Total shared staffing hours are divided
506.19 proportionally by the number of individuals who receive the shared service provisions.

506.20 ~~(m)~~ (n) "Staffing ratio" means the number of recipients a service provider employee
506.21 supports during a unit of service based on a uniform assessment tool, provider observation,
506.22 case history, and the recipient's services of choice, and not based on the staffing ratios under
506.23 section 245D.31.

506.24 ~~(n)~~ (o) "Unit of service" means the following:

506.25 (1) for residential support services under subdivision 6, a unit of service is a day. Any
506.26 portion of any calendar day, within allowable Medicaid rules, where an individual spends
506.27 time in a residential setting is billable as a day;

506.28 (2) for day services under subdivision 7:

506.29 (i) for day training and habilitation services, a unit of service is either:

506.30 (A) a day unit of service is defined as six or more hours of time spent providing direct
506.31 services and transportation; or

165.28 ~~(h)~~ (i) "Median" means the amount that divides distribution into two equal groups,
165.29 one-half above the median and one-half below the median.

165.30 ~~(h)~~ (j) "Payment or rate" means reimbursement to an eligible provider for services
165.31 provided to a qualified individual based on an approved service authorization.

166.1 ~~(j)~~ (k) "Rates management system" means a Web-based software application that uses
166.2 a framework and component values, as determined by the commissioner, to establish service
166.3 rates.

166.4 ~~(k)~~ (l) "Recipient" means a person receiving home and community-based services funded
166.5 under any of the disability waivers.

166.6 ~~(k)~~ (m) "Shared staffing" means time spent by employees, not defined under paragraph
166.7 ~~(g)~~ (g), providing or available to provide more than one individual with direct support and
166.8 assistance with activities of daily living as defined under section 256B.0659, subdivision
166.9 1, paragraph (b); instrumental activities of daily living as defined under section 256B.0659,
166.10 subdivision 1, paragraph (i); ancillary activities needed to support individual services; and
166.11 training to participants, and is based on the requirements in each individual's coordinated
166.12 service and support plan under section 245D.02, subdivision 4b; any coordinated service
166.13 and support plan addendum under section 245D.02, subdivision 4c; an assessment tool; and
166.14 provider observation of an individual's service need. Total shared staffing hours are divided
166.15 proportionally by the number of individuals who receive the shared service provisions.

166.16 ~~(m)~~ (n) "Staffing ratio" means the number of recipients a service provider employee
166.17 supports during a unit of service based on a uniform assessment tool, provider observation,
166.18 case history, and the recipient's services of choice, and not based on the staffing ratios under
166.19 section 245D.31.

166.20 ~~(n)~~ (o) "Unit of service" means the following:

166.21 (1) for residential support services under subdivision 6, a unit of service is a day. Any
166.22 portion of any calendar day, within allowable Medicaid rules, where an individual spends
166.23 time in a residential setting is billable as a day;

166.24 (2) for day services under subdivision 7:

166.25 (i) for day training and habilitation services, a unit of service is either:

166.26 (A) a day unit of service is defined as six or more hours of time spent providing direct
166.27 services and transportation; or

507.1 (B) a partial day unit of service is defined as fewer than six hours of time spent providing
507.2 direct services and transportation; and

507.3 (C) for new day service recipients after January 1, 2014, 15 minute units of service must
507.4 be used for fewer than six hours of time spent providing direct services and transportation;

507.5 (ii) for adult day and structured day services, a unit of service is a day or 15 minutes. A
507.6 day unit of service is six or more hours of time spent providing direct services;

507.7 (iii) for prevocational services, a unit of service is a day or an hour. A day unit of service
507.8 is six or more hours of time spent providing direct service;

507.9 (3) for unit-based services with programming under subdivision 8:

507.10 (i) for supported living services, a unit of service is a day or 15 minutes. When a day
507.11 rate is authorized, any portion of a calendar day where an individual receives services is
507.12 billable as a day; and

507.13 (ii) for all other services, a unit of service is 15 minutes; and

507.14 (4) for unit-based services without programming under subdivision 9, a unit of service
507.15 is 15 minutes.

507.16 Sec. 24. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 3, is
507.17 amended to read:

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

507.22 (1) 24-hour customized living;

507.23 (2) adult day care;

507.24 (3) adult day care bath;

507.25 ~~(4) behavioral programming;~~

507.26 ~~(5) (4) companion services;~~

166.28 (B) a partial day unit of service is defined as fewer than six hours of time spent providing
166.29 direct services and transportation; and

166.30 (C) for new day service recipients after January 1, 2014, 15 minute units of service must
166.31 be used for fewer than six hours of time spent providing direct services and transportation;

167.1 (ii) for adult day and structured day services, a unit of service is a day or 15 minutes. A
167.2 day unit of service is six or more hours of time spent providing direct services;

167.3 (iii) for prevocational services, a unit of service is a day or an hour. A day unit of service
167.4 is six or more hours of time spent providing direct service;

167.5 (3) for unit-based services with programming under subdivision 8:

167.6 (i) for supported living services, a unit of service is a day or 15 minutes. When a day
167.7 rate is authorized, any portion of a calendar day where an individual receives services is
167.8 billable as a day; and

167.9 (ii) for all other services, a unit of service is 15 minutes; and

167.10 (4) for unit-based services without programming under subdivision 9, a unit of service
167.11 is 15 minutes.

167.12 Sec. 16. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 3, is
167.13 amended to read:

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

167.18 (1) 24-hour customized living;

167.19 (2) adult day care;

167.20 (3) adult day care bath;

167.21 ~~(4) behavioral programming;~~

167.22 ~~(5) (4) companion services;~~

507.27 ~~(6)~~ (5) customized living;
507.28 ~~(7)~~ (6) day training and habilitation;
507.29 (7) employment development services;
507.30 (8) employment exploration services;
508.1 (9) employment support services;
508.2 ~~(8)~~ (10) housing access coordination;
508.3 ~~(9)~~ (11) independent living skills;
508.4 (12) independent living skills specialist services;
508.5 (13) individualized home supports;
508.6 ~~(10)~~ (14) in-home family support;
508.7 ~~(11)~~ (15) night supervision;
508.8 ~~(12)~~ (16) personal support;
508.9 (17) positive support service;
508.10 ~~(13)~~ (18) prevocational services;
508.11 ~~(14)~~ (19) residential care services;
508.12 ~~(15)~~ (20) residential support services;
508.13 ~~(16)~~ (21) respite services;
508.14 ~~(17)~~ (22) structured day services;
508.15 ~~(18)~~ (23) supported employment services;
508.16 ~~(19)~~ (24) supported living services;

167.23 ~~(6)~~ (5) customized living;
167.24 ~~(7)~~ (6) day training and habilitation;
167.25 (7) employment development services;
167.26 (8) employment exploration services;
167.27 (9) employment support services;
167.28 ~~(8)~~ (10) housing access coordination;
167.29 ~~(9)~~ (11) independent living skills;
168.1 (12) independent living skills specialist services;
168.2 (13) individualized home supports;
168.3 ~~(10)~~ (14) in-home family support;
168.4 ~~(11)~~ (15) night supervision;
168.5 ~~(12)~~ (16) personal support;
168.6 (17) positive support service;
168.7 ~~(13)~~ (18) prevocational services;
168.8 ~~(14)~~ (19) residential care services;
168.9 ~~(15)~~ (20) residential support services;
168.10 ~~(16)~~ (21) respite services;
168.11 ~~(17)~~ (22) structured day services;
168.12 ~~(18)~~ (23) supported employment services;
168.13 ~~(19)~~ (24) supported living services;

508.17 ~~(20)~~ (25) transportation services;

508.18 ~~(21) individualized home supports;~~

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

508.20 ~~(23) employment exploration services;~~

508.21 ~~(24) employment development services;~~

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

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

508.25 Sec. 25. Minnesota Statutes 2016, section 256B.4914, subdivision 4, is amended to read:

508.26 Subd. 4. **Data collection for rate determination.** (a) Rates for applicable home and
508.27 community-based waived services, including rate exceptions under subdivision 12, are
508.28 set by the rates management system.

509.1 (b) Data for services under section 256B.4913, subdivision 4a, shall be collected in a
509.2 manner prescribed by the commissioner.

509.3 (c) Data and information in the rates management system may be used to calculate an
509.4 individual's rate.

509.5 (d) Service providers, with information from the community support plan and oversight
509.6 by lead agencies, shall provide values and information needed to calculate an individual's
509.7 rate into the rates management system. The determination of service levels must be part of
509.8 a discussion with members of the support team as defined in section 245D.02, subdivision
509.9 34. This discussion must occur prior to the final establishment of each individual's rate. The
509.10 values and information include:

509.11 (1) shared staffing hours;

509.12 (2) individual staffing hours;

509.13 (3) direct registered nurse hours;

509.14 (4) direct licensed practical nurse hours;

168.14 ~~(20)~~ (25) transportation services;

168.15 ~~(21) individualized home supports;~~

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

168.17 ~~(23) employment exploration services;~~

168.18 ~~(24) employment development services;~~

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

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

168.22 Sec. 17. Minnesota Statutes 2016, section 256B.4914, subdivision 4, is amended to read:

168.23 Subd. 4. **Data collection for rate determination.** (a) Rates for applicable home and
168.24 community-based waived services, including rate exceptions under subdivision 12, are
168.25 set by the rates management system.

168.26 (b) Data for services under section 256B.4913, subdivision 4a, shall be collected in a
168.27 manner prescribed by the commissioner.

169.1 (c) Data and information in the rates management system may be used to calculate an
169.2 individual's rate.

169.3 (d) Service providers, with information from the community support plan and oversight
169.4 by lead agencies, shall provide values and information needed to calculate an individual's
169.5 rate into the rates management system. The determination of service levels must be part of
169.6 a discussion with members of the support team as defined in section 245D.02, subdivision
169.7 34. This discussion must occur prior to the final establishment of each individual's rate. The
169.8 values and information include:

169.9 (1) shared staffing hours;

169.10 (2) individual staffing hours;

169.11 (3) direct registered nurse hours;

169.12 (4) direct licensed practical nurse hours;

509.15 (5) staffing ratios;

509.16 (6) information to document variable levels of service qualification for variable levels
509.17 of reimbursement in each framework;

509.18 (7) shared or individualized arrangements for unit-based services, including the staffing
509.19 ratio;

509.20 (8) number of trips and miles for transportation services; and

509.21 (9) service hours provided through monitoring technology.

509.22 (e) Updates to individual data must include:

509.23 (1) data for each individual that is updated annually when renewing service plans; and

509.24 (2) requests by individuals or lead agencies to update a rate whenever there is a change
509.25 in an individual's service needs, with accompanying documentation.

509.26 (f) Lead agencies shall review and approve all services reflecting each individual's needs,
509.27 and the values to calculate the final payment rate for services with variables under
509.28 subdivisions 6, 7, 8, and 9 for each individual. Lead agencies must notify the individual and
509.29 the service provider of the final agreed-upon values and rate, and provide information that
509.30 is identical to what was entered into the rates management system. If a value used was
509.31 mistakenly or erroneously entered and used to calculate a rate, a provider may petition lead
510.1 agencies to correct it. Lead agencies must respond to these requests. When responding to
510.2 the request, the lead agency must consider:

510.3 (1) meeting the health and welfare needs of the individual or individuals receiving
510.4 services by service site, identified in their coordinated service and support plan under section
510.5 245D.02, subdivision 4b, and any addendum under section 245D.02, subdivision 4c;

510.6 (2) meeting the requirements for staffing under subdivision 2, paragraphs ~~(f)~~ (g), ~~(h)~~ (m),
510.7 and ~~(n)~~ (n); and meeting or exceeding the licensing standards for staffing required under
510.8 section 245D.09, subdivision 1; and

510.9 (3) meeting the staffing ratio requirements under subdivision 2, paragraph (n), and
510.10 meeting or exceeding the licensing standards for staffing required under section 245D.31.

510.11 Sec. 26. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 5, is
510.12 amended to read:

169.13 (5) staffing ratios;

169.14 (6) information to document variable levels of service qualification for variable levels
169.15 of reimbursement in each framework;

169.16 (7) shared or individualized arrangements for unit-based services, including the staffing
169.17 ratio;

169.18 (8) number of trips and miles for transportation services; and

169.19 (9) service hours provided through monitoring technology.

169.20 (e) Updates to individual data must include:

169.21 (1) data for each individual that is updated annually when renewing service plans; and

169.22 (2) requests by individuals or lead agencies to update a rate whenever there is a change
169.23 in an individual's service needs, with accompanying documentation.

169.24 (f) Lead agencies shall review and approve all services reflecting each individual's needs,
169.25 and the values to calculate the final payment rate for services with variables under
169.26 subdivisions 6, 7, 8, and 9 for each individual. Lead agencies must notify the individual and
169.27 the service provider of the final agreed-upon values and rate, and provide information that
169.28 is identical to what was entered into the rates management system. If a value used was
169.29 mistakenly or erroneously entered and used to calculate a rate, a provider may petition lead
169.30 agencies to correct it. Lead agencies must respond to these requests. When responding to
169.31 the request, the lead agency must consider:

170.1 (1) meeting the health and welfare needs of the individual or individuals receiving
170.2 services by service site, identified in their coordinated service and support plan under section
170.3 245D.02, subdivision 4b, and any addendum under section 245D.02, subdivision 4c;

170.4 (2) meeting the requirements for staffing under subdivision 2, paragraphs ~~(f)~~ (g), ~~(h)~~ (m),
170.5 and ~~(n)~~ (n); and meeting or exceeding the licensing standards for staffing required under
170.6 section 245D.09, subdivision 1; and

170.7 (3) meeting the staffing ratio requirements under subdivision 2, paragraph (n), and
170.8 meeting or exceeding the licensing standards for staffing required under section 245D.31.

170.9 Sec. 18. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 5, is
170.10 amended to read:

510.13 Subd. 5. **Base wage index and standard component values.** (a) The base wage index
510.14 is established to determine staffing costs associated with providing services to individuals
510.15 receiving home and community-based services. For purposes of developing and calculating
510.16 the proposed base wage, Minnesota-specific wages taken from job descriptions and standard
510.17 occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in
510.18 the most recent edition of the Occupational Handbook must be used. The base wage index
510.19 must be calculated as follows:

510.20 (1) for residential direct care staff, the sum of:

510.21 (i) 15 percent of the subtotal of 50 percent of the median wage for personal and home
510.22 health aide (SOC code 39-9021); 30 percent of the median wage for nursing assistant (SOC
510.23 code 31-1014); and 20 percent of the median wage for social and human services aide (SOC
510.24 code 21-1093); and

510.25 (ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide
510.26 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
510.27 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code
510.28 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
510.29 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

510.30 (2) for day services, 20 percent of the median wage for nursing assistant (SOC code
510.31 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
510.32 and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

511.1 (3) for residential asleep-overnight staff, the wage is the minimum wage in Minnesota
511.2 for large employers, except in a family foster care setting, the wage is 36 percent of the
511.3 minimum wage in Minnesota for large employers;

511.4 (4) for behavior program analyst staff, 100 percent of the median wage for mental health
511.5 counselors (SOC code 21-1014);

511.6 (5) for behavior program professional staff, 100 percent of the median wage for clinical
511.7 counseling and school psychologist (SOC code 19-3031);

511.8 (6) for behavior program specialist staff, 100 percent of the median wage for psychiatric
511.9 technicians (SOC code 29-2053);

511.10 (7) for supportive living services staff, 20 percent of the median wage for nursing assistant
511.11 (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
511.12 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
511.13 21-1093);

170.11 Subd. 5. **Base wage index and standard component values.** (a) The base wage index
170.12 is established to determine staffing costs associated with providing services to individuals
170.13 receiving home and community-based services. For purposes of developing and calculating
170.14 the proposed base wage, Minnesota-specific wages taken from job descriptions and standard
170.15 occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in
170.16 the most recent edition of the Occupational Handbook must be used. The base wage index
170.17 must be calculated as follows:

170.18 (1) for residential direct care staff, the sum of:

170.19 (i) 15 percent of the subtotal of 50 percent of the median wage for personal and home
170.20 health aide (SOC code 39-9021); 30 percent of the median wage for nursing assistant (SOC
170.21 code 31-1014); and 20 percent of the median wage for social and human services aide (SOC
170.22 code 21-1093); and

170.23 (ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide
170.24 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
170.25 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code
170.26 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
170.27 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

170.28 (2) for day services, 20 percent of the median wage for nursing assistant (SOC code
170.29 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
170.30 and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

170.31 (3) for residential asleep-overnight staff, the wage is the minimum wage in Minnesota
170.32 for large employers, except in a family foster care setting, the wage is 36 percent of the
170.33 minimum wage in Minnesota for large employers;

171.1 (4) for behavior program analyst staff, 100 percent of the median wage for mental health
171.2 counselors (SOC code 21-1014);

171.3 (5) for behavior program professional staff, 100 percent of the median wage for clinical
171.4 counseling and school psychologist (SOC code 19-3031);

171.5 (6) for behavior program specialist staff, 100 percent of the median wage for psychiatric
171.6 technicians (SOC code 29-2053);

171.7 (7) for supportive living services staff, 20 percent of the median wage for nursing assistant
171.8 (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
171.9 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
171.10 21-1093);

511.14 (8) for housing access coordination staff, 100 percent of the median wage for community
511.15 and social services specialist (SOC code 21-1099);

511.16 (9) for in-home family support staff, 20 percent of the median wage for nursing aide
511.17 (SOC code 31-1012); 30 percent of the median wage for community social service specialist
511.18 (SOC code 21-1099); 40 percent of the median wage for social and human services aide
511.19 (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC
511.20 code 29-2053);

511.21 (10) for individualized home supports services staff, 40 percent of the median wage for
511.22 community social service specialist (SOC code 21-1099); 50 percent of the median wage
511.23 for social and human services aide (SOC code 21-1093); and ten percent of the median
511.24 wage for psychiatric technician (SOC code 29-2053);

511.25 (11) for independent living skills staff, 40 percent of the median wage for community
511.26 social service specialist (SOC code 21-1099); 50 percent of the median wage for social and
511.27 human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric
511.28 technician (SOC code 29-2053);

511.29 (12) for independent living skills specialist staff, 100 percent of mental health and
511.30 substance abuse social worker (SOC code 21-1023);

511.31 (13) for supported employment staff, 20 percent of the median wage for nursing assistant
511.32 (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
512.1 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
512.2 21-1093);

512.3 (14) for employment support services staff, 50 percent of the median wage for
512.4 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for
512.5 community and social services specialist (SOC code 21-1099);

512.6 (15) for employment exploration services staff, 50 percent of the median wage for
512.7 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for
512.8 community and social services specialist (SOC code 21-1099);

512.9 (16) for employment development services staff, 50 percent of the median wage for
512.10 education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent
512.11 of the median wage for community and social services specialist (SOC code 21-1099);

512.12 (17) for adult companion staff, 50 percent of the median wage for personal and home
512.13 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant
512.14 (SOC code 31-1014);

171.11 (8) for housing access coordination staff, 100 percent of the median wage for community
171.12 and social services specialist (SOC code 21-1099);

171.13 (9) for in-home family support staff, 20 percent of the median wage for nursing aide
171.14 (SOC code 31-1012); 30 percent of the median wage for community social service specialist
171.15 (SOC code 21-1099); 40 percent of the median wage for social and human services aide
171.16 (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC
171.17 code 29-2053);

171.18 (10) for individualized home supports services staff, 40 percent of the median wage for
171.19 community social service specialist (SOC code 21-1099); 50 percent of the median wage
171.20 for social and human services aide (SOC code 21-1093); and ten percent of the median
171.21 wage for psychiatric technician (SOC code 29-2053);

171.22 (11) for independent living skills staff, 40 percent of the median wage for community
171.23 social service specialist (SOC code 21-1099); 50 percent of the median wage for social and
171.24 human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric
171.25 technician (SOC code 29-2053);

171.26 (12) for independent living skills specialist staff, 100 percent of mental health and
171.27 substance abuse social worker (SOC code 21-1023);

171.28 (13) for supported employment staff, 20 percent of the median wage for nursing assistant
171.29 (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
171.30 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
171.31 21-1093);

172.1 (14) for employment support services staff, 50 percent of the median wage for
172.2 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for
172.3 community and social services specialist (SOC code 21-1099);

172.4 (15) for employment exploration services staff, 50 percent of the median wage for
172.5 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for
172.6 community and social services specialist (SOC code 21-1099);

172.7 (16) for employment development services staff, 50 percent of the median wage for
172.8 education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent
172.9 of the median wage for community and social services specialist (SOC code 21-1099);

172.10 (17) for adult companion staff, 50 percent of the median wage for personal and home
172.11 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant
172.12 (SOC code 31-1014);

512.15 (18) for night supervision staff, 20 percent of the median wage for home health aide
512.16 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
512.17 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code
512.18 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
512.19 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

512.20 (19) for respite staff, 50 percent of the median wage for personal and home care aide
512.21 (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code
512.22 31-1014);

512.23 (20) for personal support staff, 50 percent of the median wage for personal and home
512.24 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant
512.25 (SOC code 31-1014);

512.26 (21) for supervisory staff, 100 percent of the median wage for community and social
512.27 services specialist (SOC code 21-1099), with the exception of the supervisor of behavior
512.28 professional, behavior analyst, and behavior specialists, which is 100 percent of the median
512.29 wage for clinical counseling and school psychologist (SOC code 19-3031);

512.30 (22) for registered nurse staff, 100 percent of the median wage for registered nurses
512.31 (SOC code 29-1141); and

512.32 (23) for licensed practical nurse staff, 100 percent of the median wage for licensed
512.33 practical nurses (SOC code 29-2061).

513.1 (b) Component values for residential support services are:

513.2 (1) supervisory span of control ratio: 11 percent;

513.3 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

513.4 (3) employee-related cost ratio: 23.6 percent;

513.5 (4) general administrative support ratio: 13.25 percent;

513.6 (5) program-related expense ratio: 1.3 percent; and

513.7 (6) absence and utilization factor ratio: 3.9 percent.

513.8 (c) Component values for family foster care are:

172.13 (18) for night supervision staff, 20 percent of the median wage for home health aide
172.14 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
172.15 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code
172.16 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
172.17 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

172.18 (19) for respite staff, 50 percent of the median wage for personal and home care aide
172.19 (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code
172.20 31-1014);

172.21 (20) for personal support staff, 50 percent of the median wage for personal and home
172.22 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant
172.23 (SOC code 31-1014);

172.24 (21) for supervisory staff, 100 percent of the median wage for community and social
172.25 services specialist (SOC code 21-1099), with the exception of the supervisor of behavior
172.26 professional, behavior analyst, and behavior specialists, which is 100 percent of the median
172.27 wage for clinical counseling and school psychologist (SOC code 19-3031);

172.28 (22) for registered nurse staff, 100 percent of the median wage for registered nurses
172.29 (SOC code 29-1141); and

172.30 (23) for licensed practical nurse staff, 100 percent of the median wage for licensed
172.31 practical nurses (SOC code 29-2061).

172.32 (b) Component values for residential support services are:

173.1 (1) supervisory span of control ratio: 11 percent;

173.2 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

173.3 (3) employee-related cost ratio: 23.6 percent;

173.4 (4) general administrative support ratio: 13.25 percent;

173.5 (5) program-related expense ratio: 1.3 percent; and

173.6 (6) absence and utilization factor ratio: 3.9 percent.

173.7 (c) Component values for family foster care are:

513.9	(1) supervisory span of control ratio: 11 percent;	173.8	(1) supervisory span of control ratio: 11 percent;
513.10	(2) employee vacation, sick, and training allowance ratio: 8.71 percent;	173.9	(2) employee vacation, sick, and training allowance ratio: 8.71 percent;
513.11	(3) employee-related cost ratio: 23.6 percent;	173.10	(3) employee-related cost ratio: 23.6 percent;
513.12	(4) general administrative support ratio: 3.3 percent;	173.11	(4) general administrative support ratio: 3.3 percent;
513.13	(5) program-related expense ratio: 1.3 percent; and	173.12	(5) program-related expense ratio: 1.3 percent; and
513.14	(6) absence factor: 1.7 percent.	173.13	(6) absence factor: 1.7 percent.
513.15	(d) Component values for day services for all services are:	173.14	(d) Component values for day services for all services are:
513.16	(1) supervisory span of control ratio: 11 percent;	173.15	(1) supervisory span of control ratio: 11 percent;
513.17	(2) employee vacation, sick, and training allowance ratio: 8.71 percent;	173.16	(2) employee vacation, sick, and training allowance ratio: 8.71 percent;
513.18	(3) employee-related cost ratio: 23.6 percent;	173.17	(3) employee-related cost ratio: 23.6 percent;
513.19	(4) program plan support ratio: 5.6 percent;	173.18	(4) program plan support ratio: 5.6 percent;
513.20	(5) client programming and support ratio: ten percent;	173.19	(5) client programming and support ratio: ten percent;
513.21	(6) general administrative support ratio: 13.25 percent;	173.20	(6) general administrative support ratio: 13.25 percent;
513.22	(7) program-related expense ratio: 1.8 percent; and	173.21	(7) program-related expense ratio: 1.8 percent; and
513.23	(8) absence and utilization factor ratio: 9.4 percent.	173.22	(8) absence and utilization factor ratio: 9.4 percent.
513.24	(e) Component values for unit-based services with programming are:	173.23	(e) Component values for unit-based services with programming are:
513.25	(1) supervisory span of control ratio: 11 percent;	173.24	(1) supervisory span of control ratio: 11 percent;
513.26	(2) employee vacation, sick, and training allowance ratio: 8.71 percent;	173.25	(2) employee vacation, sick, and training allowance ratio: 8.71 percent;
513.27	(3) employee-related cost ratio: 23.6 percent;	173.26	(3) employee-related cost ratio: 23.6 percent;
514.1	(4) program plan supports ratio: 15.5 percent;	173.27	(4) program plan supports ratio: 15.5 percent;

514.2	(5) client programming and supports ratio: 4.7 percent;	174.1	(5) client programming and supports ratio: 4.7 percent;
514.3	(6) general administrative support ratio: 13.25 percent;	174.2	(6) general administrative support ratio: 13.25 percent;
514.4	(7) program-related expense ratio: 6.1 percent; and	174.3	(7) program-related expense ratio: 6.1 percent; and
514.5	(8) absence and utilization factor ratio: 3.9 percent.	174.4	(8) absence and utilization factor ratio: 3.9 percent.
514.6	(f) Component values for unit-based services without programming except respite are:	174.5	(f) Component values for unit-based services without programming except respite are:
514.7	(1) supervisory span of control ratio: 11 percent;	174.6	(1) supervisory span of control ratio: 11 percent;
514.8	(2) employee vacation, sick, and training allowance ratio: 8.71 percent;	174.7	(2) employee vacation, sick, and training allowance ratio: 8.71 percent;
514.9	(3) employee-related cost ratio: 23.6 percent;	174.8	(3) employee-related cost ratio: 23.6 percent;
514.10	(4) program plan support ratio: 7.0 percent;	174.9	(4) program plan support ratio: 7.0 percent;
514.11	(5) client programming and support ratio: 2.3 percent;	174.10	(5) client programming and support ratio: 2.3 percent;
514.12	(6) general administrative support ratio: 13.25 percent;	174.11	(6) general administrative support ratio: 13.25 percent;
514.13	(7) program-related expense ratio: 2.9 percent; and	174.12	(7) program-related expense ratio: 2.9 percent; and
514.14	(8) absence and utilization factor ratio: 3.9 percent.	174.13	(8) absence and utilization factor ratio: 3.9 percent.
514.15	(g) Component values for unit-based services without programming for respite are:	174.14	(g) Component values for unit-based services without programming for respite are:
514.16	(1) supervisory span of control ratio: 11 percent;	174.15	(1) supervisory span of control ratio: 11 percent;
514.17	(2) employee vacation, sick, and training allowance ratio: 8.71 percent;	174.16	(2) employee vacation, sick, and training allowance ratio: 8.71 percent;
514.18	(3) employee-related cost ratio: 23.6 percent;	174.17	(3) employee-related cost ratio: 23.6 percent;
514.19	(4) general administrative support ratio: 13.25 percent;	174.18	(4) general administrative support ratio: 13.25 percent;
514.20	(5) program-related expense ratio: 2.9 percent; and	174.19	(5) program-related expense ratio: 2.9 percent; and
514.21	(6) absence and utilization factor ratio: 3.9 percent.	174.20	(6) absence and utilization factor ratio: 3.9 percent.

514.22 (h) On July 1, 2017, the commissioner shall update the base wage index in paragraph
514.23 (a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor
514.24 Statistics available on December 31, 2016. The commissioner shall publish these updated
514.25 values and load them into the rate management system. On July 1, 2022, and every five
514.26 years thereafter, the commissioner shall update the base wage index in paragraph (a) based
514.27 on the most recently available wage data by SOC from the Bureau of Labor Statistics. The
514.28 commissioner shall publish these updated values and load them into the rate management
514.29 system.

515.1 (i) On July 1, 2017, the commissioner shall update the framework components in
515.2 paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision
515.3 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the
515.4 Consumer Price Index. The commissioner will adjust these values higher or lower by the
515.5 percentage change in the Consumer Price Index-All Items, United States city average
515.6 (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these
515.7 updated values and load them into the rate management system. On July 1, 2022, and every
515.8 five years thereafter, the commissioner shall update the framework components in paragraph
515.9 (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision 6, clauses
515.10 (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer
515.11 Price Index. The commissioner shall adjust these values higher or lower by the percentage
515.12 change in the CPI-U from the date of the previous update to the date of the data most recently
515.13 available prior to the scheduled update. The commissioner shall publish these updated values
515.14 and load them into the rate management system.

515.15 (j) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer
515.16 Price Index items are unavailable in the future, the commissioner shall recommend to the
515.17 legislature codes or items to update and replace missing component values.

515.18 (k) The commissioner shall increase the updated base wage index in paragraph (h) with
515.19 a competitive workforce factor as follows:

515.20 (1) upon federal approval, the competitive workforce factor is 8.35 percent;

515.21 (2) effective July 1, 2019, the competitive workforce factor is decreased to 5.5 percent;
515.22 and

515.23 (3) effective July 1, 2020, the competitive workforce factor is decreased to 1.8 percent.

174.21 (h) On July 1, 2017, the commissioner shall update the base wage index in paragraph
174.22 (a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor
174.23 Statistics available on December 31, 2016. The commissioner shall publish these updated
174.24 values and load them into the rate management system. On July January 1, 2022, and every
174.25 five two years thereafter, the commissioner shall update the base wage index in paragraph
174.26 (a) based on the most recently available wage data by SOC from the Bureau of Labor
174.27 Statistics available on December 31 of the year two years prior to the scheduled update.
174.28 The commissioner shall publish these updated values and load them into the rate management
174.29 system.

175.1 (i) On July 1, 2017, the commissioner shall update the framework components in
175.2 paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision
175.3 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the
175.4 Consumer Price Index. The commissioner will adjust these values higher or lower by the
175.5 percentage change in the Consumer Price Index-All Items, United States city average
175.6 (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these
175.7 updated values and load them into the rate management system. On July January 1, 2022,
175.8 and every five two years thereafter, the commissioner shall update the framework components
175.9 in paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5);
175.10 subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes
175.11 in the Consumer Price Index. The commissioner shall adjust these values higher or lower
175.12 by the percentage change in the CPI-U from the date of the previous update to the date of
175.13 the data most recently available on December 31 of the year two years prior to the scheduled
175.14 update. The commissioner shall publish these updated values and load them into the rate
175.15 management system.

175.16 (j) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer
175.17 Price Index items are unavailable in the future, the commissioner shall recommend to the
175.18 legislature codes or items to update and replace missing component values.

175.19 (k) The commissioner shall increase the updated base wage index in paragraph (h) with
175.20 a competitive workforce factor of 8.35 percent. The lead agencies must implement the
175.21 competitive workforce factor on the date the competitive workforce factor is effective and
175.22 not as reassessments, reauthorizations, or service plan renewals occur.

515.24 The lead agencies must implement changes to the competitive workforce factor on the dates
515.25 listed in clauses (1) to (3), and not as reassessments, reauthorizations, or service plan renewals
515.26 occur.

515.27 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
515.28 shall inform the revisor of statutes when federal approval is obtained.

175.23 **EFFECTIVE DATE.** (a) The amendments to paragraphs (h) and (i) are effective January
175.24 1, 2022, or upon federal approval, whichever is later. The commissioner shall inform the
175.25 revisor of statutes when federal approval is obtained.

175.26 (b) Paragraph (k) is effective July 1, 2018, or upon federal approval, whichever is later.
175.27 The commissioner shall inform the revisor of statutes when federal approval is obtained.

175.28 Sec. 19. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 6, is
175.29 amended to read:

175.30 Subd. 6. **Payments for residential support services.** (a) Payments for residential support
175.31 services, as defined in sections 256B.092, subdivision 11, and 256B.49, subdivision 22,
175.32 must be calculated as follows:

176.1 (1) determine the number of shared staffing and individual direct staff hours to meet a
176.2 recipient's needs provided on site or through monitoring technology;

176.3 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
176.4 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
176.5 5. This is defined as the direct-care rate;

176.6 (3) for a recipient requiring customization for deaf and hard-of-hearing language
176.7 accessibility under subdivision 12, add the customization rate provided in subdivision 12
176.8 to the result of clause (2). This is defined as the customized direct-care rate;

176.9 (4) multiply the number of shared and individual direct staff hours provided on site or
176.10 through monitoring technology and nursing hours by the appropriate staff wages in
176.11 subdivision 5, paragraph (a), or the customized direct-care rate;

176.12 (5) multiply the number of shared and individual direct staff hours provided on site or
176.13 through monitoring technology and nursing hours by the product of the supervision span
176.14 of control ratio in subdivision 5, paragraph (b), clause (1), and the appropriate supervision
176.15 wage in subdivision 5, paragraph (a), clause (21);

176.16 (6) combine the results of clauses (4) and (5), excluding any shared and individual direct
176.17 staff hours provided through monitoring technology, and multiply the result by one plus
176.18 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b),
176.19 clause (2). This is defined as the direct staffing cost;

- 176.20 (7) for employee-related expenses, multiply the direct staffing cost, excluding any shared
176.21 and individual direct staff hours provided through monitoring technology, by one plus the
176.22 employee-related cost ratio in subdivision 5, paragraph (b), clause (3);
- 176.23 (8) for client programming and supports, the commissioner shall add \$2,179; and
- 176.24 (9) for transportation, if provided, the commissioner shall add \$1,680, or \$3,000 if
176.25 customized for adapted transport, based on the resident with the highest assessed need.
- 176.26 (b) The total rate must be calculated using the following steps:
- 176.27 (1) subtotal paragraph (a), clauses (7) to (9), and the direct staffing cost of any shared
176.28 and individual direct staff hours provided through monitoring technology that was excluded
176.29 in clause (7);
- 176.30 (2) sum the standard general and administrative rate, the program-related expense ratio,
176.31 and the absence and utilization ratio; and
- 177.1 (3) divide the result of clause (1) by one minus the result of clause (2). This is the total
177.2 payment amount; ~~and~~.
- 177.3 ~~(4) adjust the result of clause (3) by a factor to be determined by the commissioner to~~
177.4 ~~adjust for regional differences in the cost of providing services.~~
- 177.5 (c) The payment methodology for customized living, 24-hour customized living, and
177.6 residential care services must be the customized living tool. Revisions to the customized
177.7 living tool must be made to reflect the services and activities unique to disability-related
177.8 recipient needs.
- 177.9 (d) For individuals enrolled prior to January 1, 2014, the days of service authorized must
177.10 meet or exceed the days of service used to convert service agreements in effect on December
177.11 1, 2013, and must not result in a reduction in spending or service utilization due to conversion
177.12 during the implementation period under section 256B.4913, subdivision 4a. If during the
177.13 implementation period, an individual's historical rate, including adjustments required under
177.14 section 256B.4913, subdivision 4a, paragraph (c), is equal to or greater than the rate
177.15 determined in this subdivision, the number of days authorized for the individual is 365.
- 177.16 (e) The number of days authorized for all individuals enrolling after January 1, 2014,
177.17 in residential services must include every day that services start and end.
- 177.18 **EFFECTIVE DATE.** This section is effective January 1, 2022.

177.19 Sec. 20. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 7, is
177.20 amended to read:

177.21 Subd. 7. **Payments for day programs.** Payments for services with day programs
177.22 including adult day care, day treatment and habilitation, prevocational services, and structured
177.23 day services must be calculated as follows:

177.24 (1) determine the number of units of service and staffing ratio to meet a recipient's needs:

177.25 (i) the staffing ratios for the units of service provided to a recipient in a typical week
177.26 must be averaged to determine an individual's staffing ratio; and

177.27 (ii) the commissioner, in consultation with service providers, shall develop a uniform
177.28 staffing ratio worksheet to be used to determine staffing ratios under this subdivision;

177.29 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
177.30 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
177.31 5;

178.1 (3) for a recipient requiring customization for deaf and hard-of-hearing language
178.2 accessibility under subdivision 12, add the customization rate provided in subdivision 12
178.3 to the result of clause (2). This is defined as the customized direct-care rate;

178.4 (4) multiply the number of day program direct staff hours and nursing hours by the
178.5 appropriate staff wage in subdivision 5, paragraph (a), or the customized direct-care rate;

178.6 (5) multiply the number of day direct staff hours by the product of the supervision span
178.7 of control ratio in subdivision 5, paragraph (d), clause (1), and the appropriate supervision
178.8 wage in subdivision 5, paragraph (a), clause (21);

178.9 (6) combine the results of clauses (4) and (5), and multiply the result by one plus the
178.10 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d), clause
178.11 (2). This is defined as the direct staffing rate;

178.12 (7) for program plan support, multiply the result of clause (6) by one plus the program
178.13 plan support ratio in subdivision 5, paragraph (d), clause (4);

178.14 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
178.15 employee-related cost ratio in subdivision 5, paragraph (d), clause (3);

178.16 (9) for client programming and supports, multiply the result of clause (8) by one plus
178.17 the client programming and support ratio in subdivision 5, paragraph (d), clause (5);

- 178.18 (10) for program facility costs, add \$19.30 per week with consideration of staffing ratios
178.19 to meet individual needs;
- 178.20 (11) for adult day bath services, add \$7.01 per 15 minute unit;
- 178.21 (12) this is the subtotal rate;
- 178.22 (13) sum the standard general and administrative rate, the program-related expense ratio,
178.23 and the absence and utilization factor ratio;
- 178.24 (14) divide the result of clause (12) by one minus the result of clause (13). This is the
178.25 total payment amount;
- 178.26 ~~(15) adjust the result of clause (14) by a factor to be determined by the commissioner~~
178.27 ~~to adjust for regional differences in the cost of providing services;~~
- 178.28 ~~(16)~~ (15) for transportation provided as part of day training and habilitation for an
178.29 individual who does not require a lift, add:
- 179.1 (i) \$10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without
179.2 a lift, \$8.83 for a shared ride in a vehicle without a lift, and \$9.25 for a shared ride in a
179.3 vehicle with a lift;
- 179.4 (ii) \$15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without
179.5 a lift, \$10.58 for a shared ride in a vehicle without a lift, and \$11.88 for a shared ride in a
179.6 vehicle with a lift;
- 179.7 (iii) \$25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without
179.8 a lift, \$13.92 for a shared ride in a vehicle without a lift, and \$16.88 for a shared ride in a
179.9 vehicle with a lift; or
- 179.10 (iv) \$33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift,
179.11 \$16.50 for a shared ride in a vehicle without a lift, and \$20.75 for a shared ride in a vehicle
179.12 with a lift; and
- 179.13 ~~(17)~~ (16) for transportation provided as part of day training and habilitation for an
179.14 individual who does require a lift, add:
- 179.15 (i) \$19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a
179.16 lift, and \$15.05 for a shared ride in a vehicle with a lift;

179.17 (ii) \$32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a
179.18 lift, and \$28.16 for a shared ride in a vehicle with a lift;

179.19 (iii) \$58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a
179.20 lift, and \$58.76 for a shared ride in a vehicle with a lift; or

179.21 (iv) \$80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift,
179.22 and \$80.93 for a shared ride in a vehicle with a lift.

179.23 **EFFECTIVE DATE.** This section is effective January 1, 2022.

179.24 Sec. 21. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 8, is
179.25 amended to read:

179.26 Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based
179.27 services with programming, including behavior programming, housing access coordination,
179.28 in-home family support, independent living skills training, independent living skills specialist
179.29 services, individualized home supports, hourly supported living services, employment
179.30 exploration services, employment development services, supported employment, and
179.31 employment support services provided to an individual outside of any day or residential
180.1 service plan must be calculated as follows, unless the services are authorized separately
180.2 under subdivision 6 or 7:

180.3 (1) determine the number of units of service to meet a recipient's needs;

180.4 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
180.5 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
180.6 5;

180.7 (3) for a recipient requiring customization for deaf and hard-of-hearing language
180.8 accessibility under subdivision 12, add the customization rate provided in subdivision 12
180.9 to the result of clause (2). This is defined as the customized direct-care rate;

180.10 (4) multiply the number of direct staff hours by the appropriate staff wage in subdivision
180.11 5, paragraph (a), or the customized direct-care rate;

180.12 (5) multiply the number of direct staff hours by the product of the supervision span of
180.13 control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision
180.14 wage in subdivision 5, paragraph (a), clause (21);

180.15 (6) combine the results of clauses (4) and (5), and multiply the result by one plus the
180.16 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (e), clause
180.17 (2). This is defined as the direct staffing rate;

180.18 (7) for program plan support, multiply the result of clause (6) by one plus the program
180.19 plan supports ratio in subdivision 5, paragraph (e), clause (4);

180.20 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
180.21 employee-related cost ratio in subdivision 5, paragraph (e), clause (3);

180.22 (9) for client programming and supports, multiply the result of clause (8) by one plus
180.23 the client programming and supports ratio in subdivision 5, paragraph (e), clause (5);

180.24 (10) this is the subtotal rate;

180.25 (11) sum the standard general and administrative rate, the program-related expense ratio,
180.26 and the absence and utilization factor ratio;

180.27 (12) divide the result of clause (10) by one minus the result of clause (11). This is the
180.28 total payment amount; and

180.29 (13) for supported employment provided in a shared manner, divide the total payment
180.30 amount in clause (12) by the number of service recipients, not to exceed three. For
180.31 employment support services provided in a shared manner, divide the total payment amount
180.32 in clause (12) by the number of service recipients, not to exceed six. For independent living
181.1 skills training and individualized home supports provided in a shared manner, divide the
181.2 total payment amount in clause (12) by the number of service recipients, not to exceed two;
181.3 and.

181.4 (14) adjust the result of clause (13) by a factor to be determined by the commissioner
181.5 to adjust for regional differences in the cost of providing services;

181.6 **EFFECTIVE DATE.** This section is effective January 1, 2022.

181.7 Sec. 22. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 9, is
181.8 amended to read:

181.9 Subd. 9. **Payments for unit-based services without programming.** Payments for
181.10 unit-based services without programming, including night supervision, personal support,
181.11 respite, and companion care provided to an individual outside of any day or residential
181.12 service plan must be calculated as follows unless the services are authorized separately
181.13 under subdivision 6 or 7:

- 181.14 (1) for all services except respite, determine the number of units of service to meet a
181.15 recipient's needs;
- 181.16 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
181.17 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;
- 181.18 (3) for a recipient requiring customization for deaf and hard-of-hearing language
181.19 accessibility under subdivision 12, add the customization rate provided in subdivision 12
181.20 to the result of clause (2). This is defined as the customized direct care rate;
- 181.21 (4) multiply the number of direct staff hours by the appropriate staff wage in subdivision
181.22 5 or the customized direct care rate;
- 181.23 (5) multiply the number of direct staff hours by the product of the supervision span of
181.24 control ratio in subdivision 5, paragraph (f), clause (1), and the appropriate supervision
181.25 wage in subdivision 5, paragraph (a), clause (21);
- 181.26 (6) combine the results of clauses (4) and (5), and multiply the result by one plus the
181.27 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (f), clause
181.28 (2). This is defined as the direct staffing rate;
- 181.29 (7) for program plan support, multiply the result of clause (6) by one plus the program
181.30 plan support ratio in subdivision 5, paragraph (f), clause (4);
- 181.31 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
181.32 employee-related cost ratio in subdivision 5, paragraph (f), clause (3);
- 182.1 (9) for client programming and supports, multiply the result of clause (8) by one plus
182.2 the client programming and support ratio in subdivision 5, paragraph (f), clause (5);
- 182.3 (10) this is the subtotal rate;
- 182.4 (11) sum the standard general and administrative rate, the program-related expense ratio,
182.5 and the absence and utilization factor ratio;
- 182.6 (12) divide the result of clause (10) by one minus the result of clause (11). This is the
182.7 total payment amount;
- 182.8 (13) for respite services, determine the number of day units of service to meet an
182.9 individual's needs;

182.10 (14) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
182.11 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

182.12 (15) for a recipient requiring deaf and hard-of-hearing customization under subdivision
182.13 12, add the customization rate provided in subdivision 12 to the result of clause (14). This
182.14 is defined as the customized direct care rate;

182.15 (16) multiply the number of direct staff hours by the appropriate staff wage in subdivision
182.16 5, paragraph (a);

182.17 (17) multiply the number of direct staff hours by the product of the supervisory span of
182.18 control ratio in subdivision 5, paragraph (g), clause (1), and the appropriate supervision
182.19 wage in subdivision 5, paragraph (a), clause (21);

182.20 (18) combine the results of clauses (16) and (17), and multiply the result by one plus
182.21 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (g),
182.22 clause (2). This is defined as the direct staffing rate;

182.23 (19) for employee-related expenses, multiply the result of clause (18) by one plus the
182.24 employee-related cost ratio in subdivision 5, paragraph (g), clause (3);

182.25 (20) this is the subtotal rate;

182.26 (21) sum the standard general and administrative rate, the program-related expense ratio,
182.27 and the absence and utilization factor ratio; and

182.28 (22) divide the result of clause (20) by one minus the result of clause (21). This is the
182.29 total payment amount; and

182.30 (23) adjust the result of clauses (12) and (22) by a factor to be determined by the
182.31 commissioner to adjust for regional differences in the cost of providing services;

183.1 **EFFECTIVE DATE.** This section is effective January 1, 2022.

183.2 Sec. 23. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 10, is
183.3 amended to read:

183.4 Subd. 10. **Updating payment values and additional information.** (a) From January
183.5 1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform
183.6 procedures to refine terms and adjust values used to calculate payment rates in this section.

515.29 Sec. 27. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 10, is
515.30 amended to read:

515.31 Subd. 10. **Updating payment values and additional information.** (a) From January
515.32 1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform
515.33 procedures to refine terms and adjust values used to calculate payment rates in this section.

516.1 (b) No later than July 1, 2014, the commissioner shall, within available resources, begin
516.2 to conduct research and gather data and information from existing state systems or other
516.3 outside sources on the following items:

516.4 (1) differences in the underlying cost to provide services and care across the state; and

516.5 (2) mileage, vehicle type, lift requirements, incidents of individual and shared rides, and
516.6 units of transportation for all day services, which must be collected from providers using
516.7 the rate management worksheet and entered into the rates management system; and

516.8 (3) the distinct underlying costs for services provided by a license holder under sections
516.9 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided
516.10 by a license holder certified under section 245D.33.

516.11 (c) Beginning January 1, 2014, through December 31, 2018, using a statistically valid
516.12 set of rates management system data, the commissioner, in consultation with stakeholders,
516.13 shall analyze for each service the average difference in the rate on December 31, 2013, and
516.14 the framework rate at the individual, provider, lead agency, and state levels. The
516.15 commissioner shall issue semiannual reports to the stakeholders on the difference in rates
516.16 by service and by county during the banding period under section 256B.4913, subdivision
516.17 4a. The commissioner shall issue the first report by October 1, 2014, and the final report
516.18 shall be issued by December 31, 2018.

516.19 (d) No later than July 1, 2014, the commissioner, in consultation with stakeholders, shall
516.20 begin the review and evaluation of the following values already in subdivisions 6 to 9, or
516.21 issues that impact all services, including, but not limited to:

516.22 (1) values for transportation rates;

516.23 (2) values for services where monitoring technology replaces staff time;

516.24 (3) values for indirect services;

516.25 (4) values for nursing;

516.26 (5) values for the facility use rate in day services, and the weightings used in the day
516.27 service ratios and adjustments to those weightings;

516.28 (6) values for workers' compensation as part of employee-related expenses;

516.29 (7) values for unemployment insurance as part of employee-related expenses;

183.7 (b) No later than July 1, 2014, the commissioner shall, within available resources, begin
183.8 to conduct research and gather data and information from existing state systems or other
183.9 outside sources on the following items:

183.10 (1) differences in the underlying cost to provide services and care across the state; and

183.11 (2) mileage, vehicle type, lift requirements, incidents of individual and shared rides, and
183.12 units of transportation for all day services, which must be collected from providers using
183.13 the rate management worksheet and entered into the rates management system; and

183.14 (3) the distinct underlying costs for services provided by a license holder under sections
183.15 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided
183.16 by a license holder certified under section 245D.33.

183.17 (c) Beginning January 1, 2014, through December 31, 2018, using a statistically valid
183.18 set of rates management system data, the commissioner, in consultation with stakeholders,
183.19 shall analyze for each service the average difference in the rate on December 31, 2013, and
183.20 the framework rate at the individual, provider, lead agency, and state levels. The
183.21 commissioner shall issue semiannual reports to the stakeholders on the difference in rates
183.22 by service and by county during the banding period under section 256B.4913, subdivision
183.23 4a. The commissioner shall issue the first report by October 1, 2014, and the final report
183.24 shall be issued by December 31, 2018.

183.25 (d) No later than July 1, 2014, the commissioner, in consultation with stakeholders, shall
183.26 begin the review and evaluation of the following values already in subdivisions 6 to 9, or
183.27 issues that impact all services, including, but not limited to:

183.28 (1) values for transportation rates;

183.29 (2) values for services where monitoring technology replaces staff time;

183.30 (3) values for indirect services;

183.31 (4) values for nursing;

184.1 (5) values for the facility use rate in day services, and the weightings used in the day
184.2 service ratios and adjustments to those weightings;

184.3 (6) values for workers' compensation as part of employee-related expenses;

184.4 (7) values for unemployment insurance as part of employee-related expenses;

516.30 (8) any changes in state or federal law with a direct impact on the underlying cost of
516.31 providing home and community-based services; ~~and~~

517.1 (9) direct care staff labor market measures; and

517.2 (10) outcome measures, determined by the commissioner, for home and community-based
517.3 services rates determined under this section.

517.4 (e) The commissioner shall report to the chairs and the ranking minority members of
517.5 the legislative committees and divisions with jurisdiction over health and human services
517.6 policy and finance with the information and data gathered under paragraphs (b) to (d), and
517.7 subdivision 10, paragraph (g), clause (6), on the following dates:

517.8 (1) January 15, 2015, with preliminary results and data;

517.9 (2) January 15, 2016, with a status implementation update, and additional data and
517.10 summary information;

517.11 (3) January 15, 2017, with the full report; and

517.12 (4) January 15, 2020, with another full report, and a full report once every four years
517.13 thereafter.

517.14 (f) The commissioner shall implement a regional adjustment factor to all rate calculations
517.15 in subdivisions 6 to 9, effective no later than January 1, 2015. Beginning July 1, 2017, the
517.16 commissioner shall renew analysis and implement changes to the regional adjustment factors
517.17 when adjustments required under subdivision 5, paragraph (h), occur. Prior to
517.18 implementation, the commissioner shall consult with stakeholders on the methodology to
517.19 calculate the adjustment.

517.20 (g) The commissioner shall provide a public notice via LISTSERV in October of each
517.21 year beginning October 1, 2014, containing information detailing legislatively approved
517.22 changes in:

517.23 (1) calculation values including derived wage rates and related employee and
517.24 administrative factors;

517.25 (2) service utilization;

517.26 (3) county and tribal allocation changes; and

184.5 (8) any changes in state or federal law with a direct impact on the underlying cost of
184.6 providing home and community-based services; ~~and~~

184.7 (9) direct care staff labor market measures; and

184.8 (10) outcome measures, determined by the commissioner, for home and community-based
184.9 services rates determined under this section.

184.10 (e) The commissioner shall report to the chairs and the ranking minority members of
184.11 the legislative committees and divisions with jurisdiction over health and human services
184.12 policy and finance with the information and data gathered under paragraphs (b) to (d) on
184.13 the following dates:

184.14 (1) January 15, 2015, with preliminary results and data;

184.15 (2) January 15, 2016, with a status implementation update, and additional data and
184.16 summary information;

184.17 (3) January 15, 2017, with the full report; and

184.18 (4) January 15, 2020, with another full report, and a full report once every four years
184.19 thereafter.

184.20 (f) The commissioner shall implement a regional adjustment factor to all rate calculations
184.21 in subdivisions 6 to 9, effective no later than January 1, 2015. Beginning July 1, 2017, the
184.22 commissioner shall renew analysis and implement changes to the regional adjustment factors
184.23 when adjustments required under subdivision 5, paragraph (h), occur. Prior to
184.24 implementation, the commissioner shall consult with stakeholders on the methodology to
184.25 calculate the adjustment.

184.26 (g) The commissioner shall provide a public notice via LISTSERV in October of each
184.27 year beginning October 1, 2014, containing information detailing legislatively approved
184.28 changes in:

184.29 (1) calculation values including derived wage rates and related employee and
184.30 administrative factors;

184.31 (2) service utilization;

185.1 (3) county and tribal allocation changes; and

517.27 (4) information on adjustments made to calculation values and the timing of those
517.28 adjustments.

517.29 The information in this notice must be effective January 1 of the following year.

517.30 (h) When the available shared staffing hours in a residential setting are insufficient to
517.31 meet the needs of an individual who enrolled in residential services after January 1, 2014,
518.1 or insufficient to meet the needs of an individual with a service agreement adjustment
518.2 described in section 256B.4913, subdivision 4a, paragraph (f), then individual staffing hours
518.3 shall be used.

518.4 (i) The commissioner shall study the underlying cost of absence and utilization for day
518.5 services. Based on the commissioner's evaluation of the data collected under this paragraph,
518.6 the commissioner shall make recommendations to the legislature by January 15, 2018, for
518.7 changes, if any, to the absence and utilization factor ratio component value for day services.

518.8 (j) Beginning July 1, 2017, the commissioner shall collect transportation and trip
518.9 information for all day services through the rates management system.

518.10 Sec. 28. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 10a, is
518.11 amended to read:

518.12 Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure
518.13 that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the
518.14 service. As determined by the commissioner, in consultation with stakeholders identified
518.15 in section 256B.4913, subdivision 5, a provider enrolled to provide services with rates
518.16 determined under this section must submit requested cost data to the commissioner to support
518.17 research on the cost of providing services that have rates determined by the disability waiver
518.18 rates system. Requested cost data may include, but is not limited to:

518.19 (1) worker wage costs;

518.20 (2) benefits paid;

518.21 (3) supervisor wage costs;

518.22 (4) executive wage costs;

518.23 (5) vacation, sick, and training time paid;

518.24 (6) taxes, workers' compensation, and unemployment insurance costs paid;

185.2 (4) information on adjustments made to calculation values and the timing of those
185.3 adjustments.

185.4 The information in this notice must be effective January 1 of the following year.

185.5 (h) When the available shared staffing hours in a residential setting are insufficient to
185.6 meet the needs of an individual who enrolled in residential services after January 1, 2014,
185.7 or insufficient to meet the needs of an individual with a service agreement adjustment
185.8 described in section 256B.4913, subdivision 4a, paragraph (f), then individual staffing hours
185.9 shall be used.

185.10 (i) The commissioner shall study the underlying cost of absence and utilization for day
185.11 services. Based on the commissioner's evaluation of the data collected under this paragraph,
185.12 the commissioner shall make recommendations to the legislature by January 15, 2018, for
185.13 changes, if any, to the absence and utilization factor ratio component value for day services.

185.14 (j) Beginning July 1, 2017, the commissioner shall collect transportation and trip
185.15 information for all day services through the rates management system.

185.16 Sec. 24. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 10a, is
185.17 amended to read:

185.18 Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure
185.19 that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the
185.20 service. As determined by the commissioner, in consultation with stakeholders identified
185.21 in section 256B.4913, subdivision 5, a provider enrolled to provide services with rates
185.22 determined under this section must submit requested cost data to the commissioner to support
185.23 research on the cost of providing services that have rates determined by the disability waiver
185.24 rates system. Requested cost data may include, but is not limited to:

185.25 (1) worker wage costs;

185.26 (2) benefits paid;

185.27 (3) supervisor wage costs;

185.28 (4) executive wage costs;

185.29 (5) vacation, sick, and training time paid;

185.30 (6) taxes, workers' compensation, and unemployment insurance costs paid;

518.25 (7) administrative costs paid;

518.26 (8) program costs paid;

518.27 (9) transportation costs paid;

518.28 (10) vacancy rates; and

518.29 (11) other data relating to costs required to provide services requested by the
518.30 commissioner.

519.1 (b) At least once in any five-year period, a provider must submit cost data for a fiscal
519.2 year that ended not more than 18 months prior to the submission date. The commissioner
519.3 shall provide each provider a 90-day notice prior to its submission due date. If a provider
519.4 fails to submit required reporting data, the commissioner shall provide notice to providers
519.5 that have not provided required data 30 days after the required submission date, and a second
519.6 notice for providers who have not provided required data 60 days after the required
519.7 submission date. The commissioner shall temporarily suspend payments to the provider if
519.8 cost data is not received 90 days after the required submission date. Withheld payments
519.9 shall be made once data is received by the commissioner.

519.10 (c) The commissioner shall conduct a random validation of data submitted under
519.11 paragraph (a) to ensure data accuracy. The commissioner shall analyze cost documentation
519.12 in paragraph (a) and provide recommendations for adjustments to cost components.

519.13 (d) The commissioner shall analyze cost documentation in paragraph (a) and, in
519.14 consultation with stakeholders identified in section 256B.4913, subdivision 5, may submit
519.15 recommendations on component values and inflationary factor adjustments to the chairs
519.16 and ranking minority members of the legislative committees with jurisdiction over human
519.17 services every four years beginning January 1, 2020. The commissioner shall make
519.18 recommendations in conjunction with reports submitted to the legislature according to
519.19 subdivision 10, paragraph (e). The commissioner shall release cost data in an aggregate
519.20 form, and cost data from individual providers shall not be released except as provided for
519.21 in current law.

519.22 (e) The commissioner, in consultation with stakeholders identified in section 256B.4913,
519.23 subdivision 5, shall develop and implement a process for providing training and technical
519.24 assistance necessary to support provider submission of cost documentation required under
519.25 paragraph (a).

185.31 (7) administrative costs paid;

186.1 (8) program costs paid;

186.2 (9) transportation costs paid;

186.3 (10) vacancy rates; and

186.4 (11) other data relating to costs required to provide services requested by the
186.5 commissioner.

186.6 (b) At least once in any five-year period, a provider must submit cost data for a fiscal
186.7 year that ended not more than 18 months prior to the submission date. The commissioner
186.8 shall provide each provider a 90-day notice prior to its submission due date. If a provider
186.9 fails to submit required reporting data, the commissioner shall provide notice to providers
186.10 that have not provided required data 30 days after the required submission date, and a second
186.11 notice for providers who have not provided required data 60 days after the required
186.12 submission date. The commissioner shall temporarily suspend payments to the provider if
186.13 cost data is not received 90 days after the required submission date. Withheld payments
186.14 shall be made once data is received by the commissioner.

186.15 (c) The commissioner shall conduct a random validation of data submitted under
186.16 paragraph (a) to ensure data accuracy. The commissioner shall analyze cost documentation
186.17 in paragraph (a) and provide recommendations for adjustments to cost components.

186.18 (d) The commissioner shall analyze cost documentation in paragraph (a) and, in
186.19 consultation with stakeholders identified in section 256B.4913, subdivision 5, may submit
186.20 recommendations on component values and inflationary factor adjustments to the chairs
186.21 and ranking minority members of the legislative committees with jurisdiction over human
186.22 services every four years beginning January 1, 2020. The commissioner shall make
186.23 recommendations in conjunction with reports submitted to the legislature according to
186.24 subdivision 10, paragraph (e). The commissioner shall release cost data in an aggregate
186.25 form, and cost data from individual providers shall not be released except as provided for
186.26 in current law.

186.27 (e) The commissioner, in consultation with stakeholders identified in section 256B.4913,
186.28 subdivision 5, shall develop and implement a process for providing training and technical
186.29 assistance necessary to support provider submission of cost documentation required under
186.30 paragraph (a).

519.26 (f) Beginning January 1, 2019, providers enrolled to provide services with rates
519.27 determined under this section shall submit labor market data to the commissioner annually.

519.28 (g) Beginning January 15, 2020, the commissioner shall publish annual reports on
519.29 provider and state-level labor market data, including, but not limited to:

519.30 (1) number of direct care staff;

519.31 (2) wages of direct care staff;

519.32 (3) benefits provided to direct care staff;

519.33 (4) direct care staff job vacancies;

520.1 (5) direct care staff retention rates; and

520.2 (6) an evaluation of the effectiveness of the competitive workforce factors.

186.31 (f) Beginning January 1, 2019, providers enrolled to provide services with rates
186.32 determined under this section shall submit labor market data to the commissioner annually,
186.33 including, but not limited to:

187.1 (1) number of direct care staff;

187.2 (2) wages of direct care staff;

187.3 (3) overtime wages of direct care staff;

187.4 (4) hours worked by direct care staff;

187.5 (5) overtime hours worked by direct care staff;

187.6 (6) benefits provided to direct care staff;

187.7 (7) direct care staff job vacancies; and

187.8 (8) direct care staff retention rates.

187.9 (g) Beginning January 15, 2020, the commissioner shall publish annual reports on
187.10 provider and state-level labor market data, including, but not limited to:

187.11 (1) number of direct care staff;

187.12 (2) wages of direct care staff;

187.16 (6) benefits provided to direct care staff;

187.17 (7) direct care staff job vacancies; and

187.18 (8) direct care staff retention rates.

187.13 (3) overtime wages of direct care staff;

187.14 (4) hours worked by direct care staff;

520.3 Sec. 29. Minnesota Statutes 2017 Supplement, section 256I.03, subdivision 8, is amended
520.4 to read:

520.5 Subd. 8. **Supplementary services.** "Supplementary services" means housing support
520.6 services provided to individuals in addition to room and board including, but not limited
520.7 to, oversight and up to 24-hour supervision, medication reminders, assistance with
520.8 transportation, arranging for meetings and appointments, and arranging for medical and
520.9 social services. Providers must comply with section 256I.04, subdivision 2h.

520.10 Sec. 30. Minnesota Statutes 2017 Supplement, section 256I.04, subdivision 2b, is amended
520.11 to read:

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

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

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

187.15 (5) overtime hours worked by direct care staff;

187.19 Sec. 25. Minnesota Statutes 2016, section 256B.5012, is amended by adding a subdivision
187.20 to read:

187.21 Subd. 18. **ICF/DD rate increase effective July 1, 2018; Steele County.** Effective July
187.22 1, 2018, the daily rate for an intermediate care facility for persons with developmental
187.23 disabilities located in Steele County that is classified as a class B facility and licensed for
187.24 16 beds is \$400. The increase under this subdivision is in addition to any other increase that
187.25 is effective on July 1, 2018.

- 520.30 (2) all staff who have direct contact with recipients meet the staff qualifications;
- 520.31 (3) the provision of housing support;
- 520.32 (4) the provision of supplementary services, if applicable;
- 521.1 (5) reports of adverse events, including recipient death or serious injury; ~~and~~
- 521.2 (6) submission of residency requirements that could result in recipient eviction; ~~and~~
- 521.3 (7) confirmation that the provider will not limit or restrict the number of hours an
- 521.4 applicant or recipient chooses to be employed, as specified in subdivision 5.
- 521.5 (c) Agreements may be terminated with or without cause by the commissioner, the
- 521.6 agency, or the provider with two calendar months prior notice. The commissioner may
- 521.7 immediately terminate an agreement under subdivision 2d.
- 521.8 Sec. 31. Minnesota Statutes 2016, section 256I.04, is amended by adding a subdivision
- 521.9 to read:
- 521.10 Subd. 2h. **Required supplementary services.** Providers of supplementary services shall
- 521.11 ensure that recipients have, at a minimum, assistance with services as identified in the
- 521.12 recipient's professional statement of need under section 256I.03, subdivision 12. Providers
- 521.13 of supplementary services shall maintain case notes with the date and description of services
- 521.14 provided to individual recipients.
- 521.15 Sec. 32. Minnesota Statutes 2016, section 256I.04, is amended by adding a subdivision
- 521.16 to read:
- 521.17 Subd. 5. **Employment.** A provider is prohibited from limiting or restricting the number
- 521.18 of hours an applicant or recipient is employed.
- 521.19 Sec. 33. Minnesota Statutes 2017 Supplement, section 256I.05, subdivision 3, is amended
- 521.20 to read:
- 521.21 Subd. 3. **Limits on rates.** When a room and board rate is used to pay for an individual's
- 521.22 room and board, the rate payable to the residence must not exceed the rate paid by an
- 521.23 individual not receiving a room and board rate ~~under this chapter~~ but who is eligible under
- 521.24 section 256I.04, subdivision 1.

187.26 Sec. 26. Minnesota Statutes 2016, section 256R.53, subdivision 2, is amended to read:

187.27 Subd. 2. Nursing facility facilities in Breckenridge border cities. The operating
187.28 payment rate of a nonprofit nursing facility that exists on January 1, 2015, is located within
188.1 the boundaries of the city cities of Breckenridge or Moorhead, and is reimbursed under this
188.2 chapter, is equal to the greater of:

188.3 (1) the operating payment rate determined under section 256R.21, subdivision 3; or

188.4 (2) the median case mix adjusted rates, including comparable rate components as
188.5 determined by the median case mix adjusted rates, including comparable rate components
188.6 as determined by the commissioner, for the equivalent case mix indices of the nonprofit
188.7 nursing facility or facilities located in an adjacent city in another state and in cities contiguous
188.8 to the adjacent city. The commissioner shall make the comparison required in this subdivision
188.9 on November 1 of each year and shall apply it to the rates to be effective on the following
188.10 January 1. The Minnesota facility's operating payment rate with a case mix index of 1.0 is
188.11 computed by dividing the adjacent city's nursing facility or facilities' median operating
188.12 payment rate with an index of 1.02 by 1.02. If the adjustments under this subdivision result
188.13 in a rate that exceeds the limits in section 256R.23, subdivision 5, and whose costs exceed
188.14 the rate in section 256R.24, subdivision 3, in a given rate year, the facility's rate shall not
188.15 be subject to the limits in section 256R.23, subdivision 5, and shall not be limited to the
188.16 rate established in section 256R.24, subdivision 3, for that rate year.

188.17 EFFECTIVE DATE. The rate increases for a facility located in Moorhead are effective
188.18 for the rate year beginning January 1, 2020, and annually thereafter.

521.25 Sec. 34. Laws 2014, chapter 312, article 27, section 76, is amended to read:

521.26 Sec. 76. **DISABILITY WAIVER REIMBURSEMENT RATE ADJUSTMENTS.**

521.27 Subdivision 1. **Historical rate.** The commissioner of human services shall adjust the
521.28 historical rates calculated in Minnesota Statutes, section 256B.4913, subdivision 4a,
521.29 paragraph (b), in effect during the banding period under Minnesota Statutes, section
522.1 256B.4913, subdivision 4a, paragraph (a), for the reimbursement rate increases effective
522.2 April 1, 2014, and any rate modification enacted during the 2014 legislative session.

522.3 ~~Subd. 2. **Residential support services.** The commissioner of human services shall adjust~~
522.4 ~~the rates calculated in Minnesota Statutes, section 256B.4914, subdivision 6, paragraphs~~
522.5 ~~(b), clause (4), and (c), for the reimbursement rate increases effective April 1, 2014, and~~
522.6 ~~any rate modification enacted during the 2014 legislative session.~~

522.7 ~~Subd. 3. **Day programs.** The commissioner of human services shall adjust the rates~~
522.8 ~~calculated in Minnesota Statutes, section 256B.4914, subdivision 7, paragraph (a), clauses~~

188.19 Sec. 27. Laws 2014, chapter 312, article 27, section 76, is amended to read:

188.20 Sec. 76. **DISABILITY WAIVER REIMBURSEMENT RATE ADJUSTMENTS.**

188.21 ~~Subdivision 1. **Historical rate.** The commissioner of human services shall adjust the~~
188.22 ~~historical rates calculated in Minnesota Statutes, section 256B.4913, subdivision 4a,~~
188.23 ~~paragraph (b), in effect during the banding period under Minnesota Statutes, section~~
188.24 ~~256B.4913, subdivision 4a, paragraph (a), for the reimbursement rate increases effective~~
188.25 ~~April 1, 2014, and any rate modification enacted during the 2014 legislative session.~~

188.26 ~~Subd. 2. **Residential support services.** The commissioner of human services shall adjust~~
188.27 ~~the rates calculated in Minnesota Statutes, section 256B.4914, subdivision 6, paragraphs~~
188.28 ~~(b), clause (4), and (c), for the reimbursement rate increases effective April 1, 2014, and~~
188.29 ~~any rate modification enacted during the 2014 legislative session.~~

188.30 ~~Subd. 3. **Day programs.** The commissioner of human services shall adjust the rates~~
188.31 ~~calculated in Minnesota Statutes, section 256B.4914, subdivision 7, paragraph (a), clauses~~

522.9 (15) to (17), for the reimbursement rate increases effective April 1, 2014, and any rate
522.10 modification enacted during the 2014 legislative session.

522.11 ~~Subd. 4. **Unit-based services with programming.** The commissioner of human services~~
522.12 ~~shall adjust the rate calculated in Minnesota Statutes, section 256B.4914, subdivision 8,~~
522.13 ~~paragraph (a), clause (14), for the reimbursement rate increases effective April 1, 2014, and~~
522.14 ~~any rate modification enacted during the 2014 legislative session.~~

522.15 ~~Subd. 5. **Unit-based services without programming.** The commissioner of human~~
522.16 ~~services shall adjust the rate calculated in Minnesota Statutes, section 256B.4914, subdivision~~
522.17 ~~9, paragraph (a), clause (23), for the reimbursement rate increases effective April 1, 2014,~~
522.18 ~~and any rate modification enacted during the 2014 legislative session.~~

522.19 EFFECTIVE DATE. This section is effective upon federal approval of the competitive
522.20 workforce factor under section 26, or January 1, 2019, whichever occurs first. The
522.21 commissioner of human services shall notify the revisor if this section becomes effective
522.22 prior to January 1, 2019.

522.23 Sec. 35. Laws 2017, First Special Session chapter 6, article 1, section 52, is amended to
522.24 read:

522.25 Sec. 52. **RANDOM MOMENT TIME STUDY EVALUATION REQUIRED.**

522.26 The commissioner of human services shall implement administrative efficiencies and
522.27 evaluate the random moment time study methodology for reimbursement of costs associated
522.28 with county duties required under Minnesota Statutes, section 256B.0911. The evaluation
522.29 must determine whether random moment is efficient and effective in supporting functions
522.30 of assessment and support planning and the purpose under Minnesota Statutes, section
522.31 256B.0911, subdivision 1. The commissioner shall submit a report to the chairs and ranking
522.32 minority members of the house of representatives and senate committees with jurisdiction
522.33 over health and human services by January 15, 2019. The report must include at least one
523.1 option for a flat-rate payment methodology for long-term care consultation assessment and
523.2 support planning services, draft legislation to implement the flat-rate options, a fiscal analysis
523.3 of the flat-rate options, and a policy analysis of the flat-rate options, including the
523.4 commissioner's rationale for supporting or opposing the option that is, in the commissioner's
523.5 opinion, the best of the flat-rate options.

523.6 Sec. 36. Laws 2017, First Special Session chapter 6, article 3, section 49, is amended to
523.7 read:

523.8 Sec. 49. **ELECTRONIC SERVICE DELIVERY DOCUMENTATION SYSTEM**
523.9 **VISIT VERIFICATION.**

523.10 Subdivision 1. **Documentation; establishment.** The commissioner of human services
523.11 shall establish implementation requirements and standards for an electronic service delivery

188.32 (15) to (17), for the reimbursement rate increases effective April 1, 2014, and any rate
188.33 modification enacted during the 2014 legislative session.

189.1 ~~Subd. 4. **Unit-based services with programming.** The commissioner of human services~~
189.2 ~~shall adjust the rate calculated in Minnesota Statutes, section 256B.4914, subdivision 8,~~
189.3 ~~paragraph (a), clause (14), for the reimbursement rate increases effective April 1, 2014, and~~
189.4 ~~any rate modification enacted during the 2014 legislative session.~~

189.5 ~~Subd. 5. **Unit-based services without programming.** The commissioner of human~~
189.6 ~~services shall adjust the rate calculated in Minnesota Statutes, section 256B.4914, subdivision~~
189.7 ~~9, paragraph (a), clause (23), for the reimbursement rate increases effective April 1, 2014,~~
189.8 ~~and any rate modification enacted during the 2014 legislative session.~~

189.9 EFFECTIVE DATE. This section is effective January 1, 2019.

189.10 Sec. 28. Laws 2017, First Special Session chapter 6, article 3, section 49, is amended to
189.11 read:

189.12 Sec. 49. **ELECTRONIC SERVICE DELIVERY DOCUMENTATION SYSTEM**
189.13 **VISIT VERIFICATION.**

189.14 Subdivision 1. **Documentation; establishment.** The commissioner of human services
189.15 shall establish implementation requirements and standards for an electronic service delivery

523.12 ~~documentation system~~ visit verification to comply with the 21st Century Cures Act, Public
523.13 Law 114-255. Within available appropriations, the commissioner shall take steps to comply
523.14 with the electronic visit verification requirements in the 21st Century Cures Act, Public
523.15 Law 114-255.

523.16 Subd. 2. **Definitions.** (a) For purposes of this section, the terms in this subdivision have
523.17 the meanings given them.

523.18 (b) "Electronic ~~service delivery documentation~~ visit verification" means the electronic
523.19 documentation of the:

523.20 (1) type of service performed;

523.21 (2) individual receiving the service;

523.22 (3) date of the service;

523.23 (4) location of the service delivery;

523.24 (5) individual providing the service; and

523.25 (6) time the service begins and ends.

523.26 (c) "Electronic ~~service delivery documentation~~ visit verification system" means a system
523.27 that provides electronic ~~service delivery documentation~~ verification of services that complies
523.28 with the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision
523.29 3.

523.30 (d) "Service" means one of the following:

524.1 (1) personal care assistance services as defined in Minnesota Statutes, section 256B.0625,
524.2 subdivision 19a, and provided according to Minnesota Statutes, section 256B.0659; ~~or~~

524.3 (2) community first services and supports under Minnesota Statutes, section 256B.85;

524.4 (3) home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

524.5 or

524.6 (4) other medical supplies and equipment or home and community-based services that
524.7 are required to be electronically verified by the 21st Century Cures Act, Public Law 114-255.

189.16 ~~documentation system~~ visit verification to comply with the 21st Century Cures Act, Public
189.17 Law 114-255. Within available appropriations, the commissioner shall take steps to comply
189.18 with the electronic visit verification requirements in the 21st Century Cures Act, Public
189.19 Law 114-255.

189.20 Subd. 2. **Definitions.** (a) For purposes of this section, the terms in this subdivision have
189.21 the meanings given them.

189.22 (b) "Electronic ~~service delivery documentation~~ visit verification" means the electronic
189.23 documentation of the:

189.24 (1) type of service performed;

189.25 (2) individual receiving the service;

189.26 (3) date of the service;

189.27 (4) location of the service delivery;

189.28 (5) individual providing the service; and

189.29 (6) time the service begins and ends.

189.30 (c) "Electronic ~~service delivery documentation~~ visit verification system" means a system
189.31 that provides electronic ~~service delivery documentation~~ verification of services that complies
190.1 with the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision
190.2 3.

190.3 (d) "Service" means one of the following:

190.4 (1) personal care assistance services as defined in Minnesota Statutes, section 256B.0625,
190.5 subdivision 19a, and provided according to Minnesota Statutes, section 256B.0659; ~~or~~

190.6 (2) community first services and supports under Minnesota Statutes, section 256B.85;

190.7 (3) home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

190.8 or

190.9 (4) other medical supplies and equipment or home and community-based services that
190.10 are required to be electronically verified by the 21st Century Cures Act, Public Law 114-255.

524.8 Subd. 3. System requirements. (a) In developing implementation requirements for an
524.9 electronic ~~service delivery documentation system~~ visit verification, the commissioner shall
524.10 ~~consider electronic visit verification systems and other electronic service delivery~~
524.11 ~~documentation methods. The commissioner shall convene stakeholders that will be impacted~~
524.12 ~~by an electronic service delivery system, including service providers and their representatives,~~
524.13 ~~service recipients and their representatives, and, as appropriate, those with expertise in the~~
524.14 ~~development and operation of an electronic service delivery documentation system, to ensure~~
524.15 that the requirements:

524.16 (1) are minimally administratively and financially burdensome to a provider;

524.17 (2) are minimally burdensome to the service recipient and the least disruptive to the
524.18 service recipient in receiving and maintaining allowed services;

524.19 (3) consider existing best practices and use of electronic ~~service delivery documentation~~
524.20 visit verification;

524.21 (4) are conducted according to all state and federal laws;

524.22 (5) are effective methods for preventing fraud when balanced against the requirements
524.23 of clauses (1) and (2); and

524.24 (6) are consistent with the Department of Human Services' policies related to covered
524.25 services, flexibility of service use, and quality assurance.

524.26 (b) The commissioner shall make training available to providers on the electronic ~~service~~
524.27 ~~delivery documentation~~ visit verification system requirements.

524.28 (c) The commissioner shall establish baseline measurements related to preventing fraud
524.29 and establish measures to determine the effect of electronic ~~service delivery documentation~~
524.30 visit verification requirements on program integrity.

524.31 (d) The commissioner shall make a state-selected electronic visit verification system
524.32 available to providers of services.

525.1 Subd. 3a. Provider requirements. (a) Providers of services may select their own
525.2 electronic visit verification system that meets the requirements established by the
525.3 commissioner.

190.11 Subd. 3. Requirements. (a) In developing implementation requirements for an electronic
190.12 ~~service delivery documentation system~~ visit verification, the commissioner shall ~~consider~~
190.13 ~~electronic visit verification systems and other electronic service delivery documentation~~
190.14 ~~methods. The commissioner shall convene stakeholders that will be impacted by an electronic~~
190.15 ~~service delivery system, including service providers and their representatives, service~~
190.16 ~~recipients and their representatives, and, as appropriate, those with expertise in the~~
190.17 ~~development and operation of an electronic service delivery documentation system, to ensure~~
190.18 that the requirements:

190.19 (1) are minimally administratively and financially burdensome to a provider;

190.20 (2) are minimally burdensome to the service recipient and the least disruptive to the
190.21 service recipient in receiving and maintaining allowed services;

190.22 (3) consider existing best practices and use of electronic ~~service delivery documentation~~
190.23 visit verification;

190.24 (4) are conducted according to all state and federal laws;

190.25 (5) are effective methods for preventing fraud when balanced against the requirements
190.26 of clauses (1) and (2); and

190.27 (6) are consistent with the Department of Human Services' policies related to covered
190.28 services, flexibility of service use, and quality assurance.

190.29 (b) The commissioner shall make training available to providers on the electronic ~~service~~
190.30 ~~delivery documentation~~ visit verification system requirements.

191.1 (c) The commissioner shall establish baseline measurements related to preventing fraud
191.2 and establish measures to determine the effect of electronic ~~service delivery documentation~~
191.3 visit verification requirements on program integrity.

191.4 (d) The commissioner shall make a state-selected electronic visit verification system
191.5 available to providers of services.

191.6 Subd. 3a. Provider requirements. (a) Providers of services may select their own
191.7 electronic visit verification system that meets the requirements established by the
191.8 commissioner.

525.4 (b) All electronic visit verification systems used by providers to comply with the
525.5 requirements established by the commissioner must provide data to the commissioner in a
525.6 format and at a frequency to be established by the commissioner.

525.7 (c) Providers must implement the electronic visit verification systems required under
525.8 this section by January 1, 2019, for personal care services and by January 1, 2023, for home
525.9 health services in accordance with the 21st Century Cures Act, Public Law 114-255, and
525.10 the Centers for Medicare and Medicaid Services guidelines. For the purposes of this
525.11 paragraph, "personal care services" and "home health services" have the meanings given
525.12 in United States Code, title 42, section 1396b(l)(5).

525.13 ~~Subd. 4. **Legislative report.** (a) The commissioner shall submit a report by January 15,~~
525.14 ~~2018, to the chairs and ranking minority members of the legislative committees with~~
525.15 ~~jurisdiction over human services with recommendations, based on the requirements of~~
525.16 ~~subdivision 3, to establish electronic service delivery documentation system requirements~~
525.17 ~~and standards. The report shall identify:~~

525.18 ~~(1) the essential elements necessary to operationalize a base-level electronic service~~
525.19 ~~delivery documentation system to be implemented by January 1, 2019; and~~

525.20 ~~(2) enhancements to the base-level electronic service delivery documentation system to~~
525.21 ~~be implemented by January 1, 2019, or after, with projected operational costs and the costs~~
525.22 ~~and benefits for system enhancements.~~

525.23 ~~(b) The report must also identify current regulations on service providers that are either~~
525.24 ~~inefficient, minimally effective, or will be unnecessary with the implementation of an~~
525.25 ~~electronic service delivery documentation system.~~

525.26 Sec. 37. **ANALYSIS OF LICENSING ADULT FOSTER CARE.**

525.27 The commissioner shall complete an analysis of settings identified by the commissioner,
525.28 in collaboration with county licensing agencies, as needing a license under Minnesota
525.29 Statutes, section 245A.03, subdivision 7, paragraph (a), clause (7), to determine if revisions
525.30 to the definition of residential program for recipients of home and community-based waiver
525.31 services are needed. The commissioner shall engage stakeholders, including licensed
525.32 providers of services governed by Minnesota Statutes, chapter 245D, and family members
525.33 who own and maintain control of the residence in which the service recipients live, in the
526.1 process of determining if revisions are needed and developing recommendations. The
526.2 commissioner shall provide a summary of the analysis and stakeholder input along with
526.3 recommendations, if any, to revise the definition of residential program under Minnesota

191.9 (b) All electronic visit verification systems used by providers to comply with the
191.10 requirements established by the commissioner must provide data to the commissioner in a
191.11 format and at a frequency to be established by the commissioner.

191.12 (c) Providers must implement the electronic visit verification systems required under
191.13 this section by January 1, 2019, for personal care services and by January 1, 2023, for home
191.14 health services in accordance with the 21st Century Cures Act, Public Law 114-255, and
191.15 the Centers for Medicare and Medicaid Services guidelines. For the purposes of this
191.16 paragraph, "personal care services" and "home health services" have the meanings given
191.17 in United States Code, title 42, section 1396b(l)(5).

191.18 ~~Subd. 4. **Legislative report.** (a) The commissioner shall submit a report by January 15,~~
191.19 ~~2018, to the chairs and ranking minority members of the legislative committees with~~
191.20 ~~jurisdiction over human services with recommendations, based on the requirements of~~
191.21 ~~subdivision 3, to establish electronic service delivery documentation system requirements~~
191.22 ~~and standards. The report shall identify:~~

191.23 ~~(1) the essential elements necessary to operationalize a base-level electronic service~~
191.24 ~~delivery documentation system to be implemented by January 1, 2019; and~~

191.25 ~~(2) enhancements to the base-level electronic service delivery documentation system to~~
191.26 ~~be implemented by January 1, 2019, or after, with projected operational costs and the costs~~
191.27 ~~and benefits for system enhancements.~~

191.28 ~~(b) The report must also identify current regulations on service providers that are either~~
191.29 ~~inefficient, minimally effective, or will be unnecessary with the implementation of an~~
191.30 ~~electronic service delivery documentation system.~~

526.4 Statutes, section 245A.02, subdivision 14, to the chairs and ranking minorities members of
526.5 the legislative committees with jurisdiction over human services by February 15, 2019.

526.6 Sec. 38. **DIRECTION TO COMMISSIONER.**

526.7 Between July 1, 2018, and December 31, 2018, or until federal approval of the
526.8 competitive workforce factor under section 26 if federal approval is obtained before
526.9 December 31, 2018, the commissioner of human services shall continue to reimburse the
526.10 Centers for Medicare and Medicaid Services for the disallowed federal share of the rate
526.11 increases described in Laws 2014, chapter 312, article 27, section 76, subdivisions 2 to 5.

526.12 **EFFECTIVE DATE.** This section is effective July 1, 2018.

526.13 Sec. 39. **DIRECTION TO COMMISSIONER; BI AND CADI WAIVER**
526.14 **CUSTOMIZED LIVING SERVICES PROVIDER LOCATED IN HENNEPIN**
526.15 **COUNTY.**

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

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

192.22 Sec. 31. **DIRECTION TO COMMISSIONER; DISABILITY WAIVER RATE**
192.23 **SYSTEM.**

192.24 Between July 1, 2018, and December 31, 2018, the commissioner of human services
192.25 shall continue to reimburse the Centers for Medicare and Medicaid Services for the
192.26 disallowed federal share of the rate increases described in Laws 2014, chapter 312, article
192.27 27, section 76, subdivisions 2 to 5.

192.28 **EFFECTIVE DATE.** This section is effective July 1, 2018.

192.1 Sec. 29. **DIRECTION TO COMMISSIONER; PRESCRIBED PEDIATRIC**
192.2 **EXTENDED CARE.**

192.3 No later than August 15, 2018, the commissioner of human services shall submit to the
192.4 federal Centers for Medicare and Medicaid Services any medical assistance state plan
192.5 amendments necessary to cover prescribed pediatric extended care center basic services
192.6 according to Minnesota Statutes, section 256B.0625, subdivision 65.

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

192.8 Sec. 30. **DIRECTION TO COMMISSIONER; BI AND CADI WAIVER**
192.9 **CUSTOMIZED LIVING SERVICES PROVIDER LOCATED IN HENNEPIN**
192.10 **COUNTY.**

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

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

526.27 Sec. 40. **DIRECTION TO COMMISSIONER.**

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

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

527.5 Sec. 41. **REVISOR'S INSTRUCTION.**

527.6 The revisor of statutes shall codify Laws 2017, First Special Session chapter 6, article
527.7 3, section 49, as amended in this act, in Minnesota Statutes, chapter 256B.

527.8 Sec. 42. **REPEALER.**

527.9 Minnesota Statutes 2016, section 256B.0705, is repealed.

527.10 **EFFECTIVE DATE.** This section is effective January 1, 2019.

192.29 Sec. 32. **REVISOR'S INSTRUCTION.**

192.30 (a) The revisor of statutes shall codify Laws 2017, First Special Session chapter 6, article
192.31 3, section 49, as amended in this article, in Minnesota Statutes, chapter 256B.

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

193.5 Sec. 33. **REPEALER.**

193.6 Minnesota Statutes 2016, section 256B.0705, is repealed.

193.7 **EFFECTIVE DATE.** This section is effective January 1, 2019.