State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FIRST SESSION

H. F. No. 2185

03/07/2019 Authored by Edelson and Zerwas
The bill was read for the first time and referred to the Committee on Health and Human Services Policy
03/18/2019 Adoption of Report: Placed on the General Register as Amended
Read for the Second Time
05/20/2019 Pursuant to Rule 4.20, returned to the Committee on Health and Human Services Policy

A bill for an act

relating to human services; modifying policy provisions governing disability services; amending Minnesota Statutes 2018, sections 245A.03, subdivision 7; 245D.03, subdivision 1; 245D.071, subdivisions 1, 3; 245D.091, subdivisions 2, 3, 4; 256B.0652, subdivision 10; 256B.0659, subdivision 3a; 256B.0911, subdivisions 1a, 3a, 3f; 256B.0915, subdivision 6; 256B.092, subdivision 1b; 256B.49, subdivisions 13, 14; 256B.4914, subdivisions 3, 14; 256B.85, subdivisions 2, 4, 5, 6, 8, 9, 10, 11, 11b, 12, 12b, 13a, 18a, by adding a subdivision.

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

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

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

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

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

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

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

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

~~(6)~~ (5) new foster care licenses or community residential setting licenses determined to be needed by the commissioner for the transition of people from the residential care waiver services to foster care services. This exception applies only when:

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

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

~~(7)~~ (6) new foster care licenses or community residential setting licenses for people receiving services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and for which a license is required. This exception does not apply to people living in their own home. For purposes of this clause, there is a presumption that a foster care or community residential setting license is required for services provided to three or more people in a dwelling unit when the setting is controlled by the provider. A license holder subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14. The exception is available until June 30, 2018. This exception is available when:

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

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

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

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

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

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

(f) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are

required to inform the commissioner whether the physical location where the foster care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

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

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

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

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

existing statewide capacity for children's residential treatment services subject to the moratorium under this paragraph and may issue an initial license for such facilities if the initial license would not increase the statewide capacity for children's residential treatment services subject to the moratorium under this paragraph.

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

Sec. 2. Minnesota Statutes 2018, section 245D.03, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

(1) intervention services, including:

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

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

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

(2) in-home support services, including:

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

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

(iii) semi-independent living services; and

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

(3) residential supports and services, including:

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

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

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

(4) day services, including:

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

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

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

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

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

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

Sec. 3. Minnesota Statutes 2018, section 245D.071, subdivision 1, is amended to read:

Subdivision 1. **Requirements for intensive support services.** Except for services identified in section 245D.03, subdivision 1, paragraph (c), clauses (1) and (2), item (ii), a license holder providing intensive support services identified in section 245D.03, subdivision 1, paragraph (c), must comply with the requirements in this section and section 245D.07, subdivisions 1, 1a, and 3. Services identified in section 245D.03, subdivision 1, paragraph (c), clauses (1) and (2), item (ii), must comply with the requirements in section 245D.07, subdivision 2.

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

Sec. 4. Minnesota Statutes 2018, section 245D.071, subdivision 3, is amended to read:

Subd. 3. **Assessment and initial service planning.** (a) Within 15 days of service initiation the license holder must complete a preliminary coordinated service and support plan addendum based on the coordinated service and support plan.

(b) Within the scope of services, the license holder must, at a minimum, complete assessments in the following areas before the 45-day planning meeting:

(1) the person's ability to self-manage health and medical needs to maintain or improve physical, mental, and emotional well-being, including, when applicable, allergies, seizures, choking, special dietary needs, chronic medical conditions, self-administration of medication or treatment orders, preventative screening, and medical and dental appointments;

(2) the person's ability to self-manage personal safety to avoid injury or accident in the service setting, including, when applicable, risk of falling, mobility, regulating water temperature, community survival skills, water safety skills, and sensory disabilities; and

(3) the person's ability to self-manage symptoms or behavior that may otherwise result in an incident as defined in section 245D.02, subdivision 11, clauses (4) to (7), suspension or termination of services by the license holder, or other symptoms or behaviors that may jeopardize the health and welfare of the person or others.

Assessments must produce information about the person that describes the person's overall strengths, functional skills and abilities, and behaviors or symptoms. Assessments must be based on the person's status within the last 12 months at the time of service initiation. Assessments based on older information must be documented and justified. Assessments must be conducted annually at a minimum or within 30 days of a written request from the person or the person's legal representative or case manager. The results must be reviewed by the support team or expanded support team as part of a service plan review.

(c) Within 45 days of service initiation, the license holder must meet with the person, the person's legal representative, the case manager, and other members of the support team or expanded support team to determine the following based on information obtained from the assessments identified in paragraph (b), the person's identified needs in the coordinated service and support plan, and the requirements in subdivision 4 and section 245D.07, subdivision 1a:

(1) the scope of the services to be provided to support the person's daily needs and activities;

(2) the person's desired outcomes and the supports necessary to accomplish the person's desired outcomes;

(3) the person's preferences for how services and supports are provided, including how the provider will support the person to have control of the person's schedule;

(4) whether the current service setting is the most integrated setting available and appropriate for the person; and

(5) how services must be coordinated across other providers licensed under this chapter serving the person and members of the support team or expanded support team to ensure continuity of care and coordination of services for the person.

(d) A discussion of how technology might be used to meet the person's desired outcomes must be included in the 45-day planning meeting and at least annually thereafter. The ~~coordinated service and support plan or~~ support plan addendum must include a summary of this discussion. The summary must include a statement regarding any decision that is made regarding the use of technology and a description of any further research that needs to be completed before a decision regarding the use of technology can be made. Nothing in this paragraph requires that the coordinated service and support plan include the use of technology for the provision of services.

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

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

(1) ethical considerations;

(2) functional assessment;

(3) functional analysis;

(4) measurement of behavior and interpretation of data;

(5) selecting intervention outcomes and strategies;

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

(7) data collection;

(8) staff and caregiver training;

(9) support plan monitoring;

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

(11) demonstrated expertise with populations being served; and

(12) must be a:

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

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

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

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

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

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

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

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

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

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

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

(3) certification as a board-certified behavior analyst or board-certified assistant behavior analyst by the Behavior Analyst Certification Board.

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

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

~~(2) have received ten hours of instruction in functional assessment and functional analysis;~~

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

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

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

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

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

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

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

(iv) 20 hours of instruction preparing written intervention strategies, designing data collection protocols, training other staff to implement positive practice behavior support

strategies, summarizing and reporting program evaluation data, analyzing program evaluation data to identify design flaws in behavioral interventions or failures in implementation fidelity, and recommending enhancements based on evaluation data; and

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

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

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

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

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

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

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

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

(b) In addition, a behavior specialist must:

~~(1) have received a minimum of four hours of training in functional assessment;~~

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

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

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

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

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

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

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

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

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

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

Sec. 8. Minnesota Statutes 2018, section 256B.0652, subdivision 10, is amended to read:

Subd. 10. **Authorization for foster care setting.** (a) Home care services provided in an adult or child foster care setting must receive authorization by the commissioner according to the limits established in subdivision 11.

(b) The commissioner may not authorize:

(1) home care services that are the responsibility of the foster care provider under the terms of the foster care placement agreement, difficulty of care rate as of January 1, 2010, and administrative rules;

(2) personal care assistance services when the foster care license holder is also the personal care provider or personal care assistant, unless the foster home is the licensed provider's primary residence as defined in section 256B.0625, subdivision 19a; or

(3) personal care assistant and home care nursing services when the licensed capacity is greater than four, unless all conditions for a variance under Minnesota Rules, part 2960.3030, subpart 3, are satisfied for a sibling, as defined in section 260C.007, subdivision 32.

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

Sec. 9. Minnesota Statutes 2018, section 256B.0659, subdivision 3a, is amended to read:

Subd. 3a. **Assessment; defined.** (a) "Assessment" means a review and evaluation of a recipient's need for personal care assistance services conducted in person. Assessments for personal care assistance services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county except when a long-term care

consultation assessment is being conducted for the purposes of determining a person's eligibility for home and community-based waiver services including personal care assistance services according to section 256B.0911. During the transition to MnCHOICES, a certified assessor may complete the assessment required in this subdivision. An in-person assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistance services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. An in-person assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistance services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistance service. A service update may be completed by telephone, used when there is no need for an increase in personal care assistance services, and used for two consecutive assessments if followed by a face-to-face assessment. A service update must be completed on a form approved by the commissioner. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments or reassessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.

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

Sec. 10. Minnesota Statutes 2018, section 256B.0911, subdivision 1a, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) consumer support grants under section 256.476; or

(iii) section 256B.85;

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

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

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

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

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

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

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

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

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

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons

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

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

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

(d) The ~~assessment must be conducted~~ assessor must conduct the assessment in a face-to-face interview with the person being assessed ~~and the person's legal representative~~. The person's legal representative must provide input during the assessment interview and may do so remotely. At the request of the person, other individuals may participate in the assessment to provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety. Except for legal representatives or family members invited by the person, persons participating in the assessment may not be a provider of service or have any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living or adult day services under section 256B.0915, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment. For a person who is to be assessed for waiver services under section 256B.092 or 256B.49, with the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs prepared by a

direct service employee ~~with at least 20 hours of service to that client~~ who is familiar with the person. ~~The person conducting the assessment or reassessment must notify the provider of the date by which this information is to be submitted.~~ This information shall be provided to the person conducting the assessment and the person or the person's legal representative, and must be considered prior to the finalization of the assessment or reassessment.

(e) The certified assessor and the individual responsible for developing the coordinated service and support plan must ensure the person has timely access to needed resources and must complete the community support plan and the coordinated service and support plan no more than 60 calendar days from the assessment visit. The person or the person's legal representative must be provided with a written community support plan within ~~40 calendar days of the assessment visit~~ the timelines established by the commissioner, regardless of whether the ~~individual~~ person is eligible for Minnesota health care programs. The commissioner shall monitor and evaluate lead agency performance in meeting timeline requirements to ensure timely access for people seeking long-term services and supports.

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

(g) The written community support plan must include:

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

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

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

(4) referral information; and

(5) informal caregiver supports, if applicable.

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

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

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

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

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

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

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

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

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

(5) information about Minnesota health care programs;

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

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

(8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in subdivision 4e and the certified assessor's

decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (6), and (b); and

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

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

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

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

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

Sec. 12. Minnesota Statutes 2018, section 256B.0911, subdivision 3f, is amended to read:

Subd. 3f. **Long-term care reassessments and community support plan updates.** Reassessments must be tailored using the professional judgment of the assessor

to the person's known needs, strengths, preferences, and circumstances. Reassessments provide information to support the person's informed choice and opportunities to express choice regarding activities that contribute to quality of life, as well as information and opportunity to identify goals related to desired employment, community activities, and preferred living environment. Reassessments allow for a review of the current support plan's effectiveness, monitoring of services, and the development of an updated person-centered community support plan. Reassessments verify continued eligibility or offer alternatives as warranted and provide an opportunity for quality assurance of service delivery. Face-to-face assessments must be conducted annually or as required by federal and state laws and rules. The certified assessor and the individual responsible for developing the coordinated service and support plan must ensure the continuity of care for the person receiving services and must complete the updated community support plan and the updated coordinated service and support plan no more than 60 calendar days from the reassessment visit. The commissioner shall monitor and evaluate lead agency performance in meeting timeline requirements to ensure timely access for people seeking long-term services and supports.

Sec. 13. Minnesota Statutes 2018, section 256B.0915, subdivision 6, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

Sec. 14. Minnesota Statutes 2018, section 256B.092, subdivision 1b, is amended to read:

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

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

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

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

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

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

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

(7) identifies specific services and the amount and frequency of the services to be provided to the person based on assessed needs, preferences, and available resources. The coordinated

service and support plan shall also specify other services the person needs that are not available;

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

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

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

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

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

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

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

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

Sec. 15. Minnesota Statutes 2018, section 256B.49, subdivision 13, is amended to read:

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

(1) finalizing the written coordinated service and support plan within ~~ten working days after the case manager receives the plan from the certified assessor~~ the timelines established by the commissioner and section 256B.0911, subdivision 3a, paragraph (e);

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

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

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

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

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

(1) finalizing the coordinated service and support plan;

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

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

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

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

(1) phasing out the use of prohibited procedures;

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

(3) accomplishment of identified outcomes.

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

Sec. 16. Minnesota Statutes 2018, section 256B.49, subdivision 14, is amended to read:

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

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

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

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

Sec. 17. Minnesota Statutes 2018, section 256B.4914, subdivision 3, is amended to read:

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

(1) 24-hour customized living;

(2) adult day care;

(3) adult day care bath;

(4) ~~behavioral programming~~ positive support services;

(5) companion services;

(6) customized living;

(7) day training and habilitation;

(8) employment development services;

(9) employment exploration services;

(10) employment support services;

~~(8)~~ (11) housing access coordination;

~~(9)~~ (12) independent living skills;

(13) independent living skills specialist services;

(14) individualized home supports;

~~(10)~~ (15) in-home family support;

~~(11)~~ (16) night supervision;

~~(12)~~ (17) personal support;

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

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

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

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

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

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

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

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

~~(21) individualized home supports;~~

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

~~(23) employment exploration services;~~

~~(24) employment development services;~~

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

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

Sec. 18. Minnesota Statutes 2018, section 256B.4914, subdivision 14, is amended to read:

Subd. 14. **Exceptions.** (a) In a format prescribed by the commissioner, lead agencies must identify individuals with exceptional needs that cannot be met under the disability waiver rate system. The commissioner shall use that information to evaluate and, if necessary, approve an alternative payment rate for those individuals. Whether granted, denied, or modified, the commissioner shall respond to all exception requests in writing. The commissioner shall include in the written response the basis for the action and provide notification of the right to appeal under paragraph (h).

(b) Lead agencies must act on an exception request within 30 days ~~and~~ from the date that the lead agency receives all application materials described in paragraph (d). Lead agencies must notify the initiator of the request of their recommendation in writing. A lead agency shall submit all exception requests along with its recommendation to the commissioner.

(c) An application for a rate exception may be submitted for the following criteria:

(1) an individual has service needs that cannot be met through additional units of service;

(2) an individual's rate determined under subdivisions 6, 7, 8, and 9 is so insufficient that it has resulted in an individual receiving a notice of discharge from the individual's provider; or

(3) an individual's service needs, including behavioral changes, require a level of service which necessitates a change in provider or which requires the current provider to propose service changes beyond those currently authorized.

(d) Exception requests must include the following information:

(1) the service needs required by each individual that are not accounted for in subdivisions 6, 7, 8, and 9;

(2) the service rate requested and the difference from the rate determined in subdivisions 6, 7, 8, and 9;

(3) a basis for the underlying costs used for the rate exception ~~and any accompanying~~ based on real costs related to the individual's extraordinary needs borne by the provider, including documentation of these costs; and

(4) any contingencies for approval.

(e) Approved rate exceptions shall be managed within lead agency allocations under sections 256B.092 and 256B.49.

(f) Individual disability waiver recipients, an interested party, or the license holder that would receive the rate exception increase may request that a lead agency submit an exception request. A lead agency that denies such a request shall notify the individual waiver recipient, interested party, or license holder of its decision and the reasons for denying the request in writing no later than 30 days after the request has been made and shall submit its denial to the commissioner in accordance with paragraph (b). The reasons for the denial must be based on the failure to meet the criteria in paragraph (c).

(g) The commissioner shall determine whether to approve or deny an exception request no more than 30 days after receiving the request. If the commissioner denies the request, the commissioner shall notify the lead agency and the individual disability waiver recipient, the interested party, and the license holder in writing of the reasons for the denial.

(h) The individual disability waiver recipient may appeal any denial of an exception request by either the lead agency or the commissioner, pursuant to sections 256.045 and 256.0451. When the denial of an exception request results in the proposed demission of a waiver recipient from a residential or day habilitation program, the commissioner shall issue a temporary stay of demission, when requested by the disability waiver recipient, consistent with the provisions of section 256.045, subdivisions 4a and 6, paragraph (c). The temporary stay shall remain in effect until the lead agency can provide an informed choice of appropriate, alternative services to the disability waiver.

(i) Providers may petition lead agencies to update values that were entered incorrectly or erroneously into the rate management system, based on past service level discussions and determination in subdivision 4, without applying for a rate exception.

(j) The starting date for the rate exception will be the later of the date of the recipient's change in support or the date of the request to the lead agency for an exception.

(k) The commissioner shall track all exception requests received and their dispositions. The commissioner shall issue quarterly public exceptions statistical reports, including the

number of exception requests received and the numbers granted, denied, withdrawn, and pending. The report shall include the average amount of time required to process exceptions.

(l) No later than January 15, 2016, the commissioner shall provide research findings on the estimated fiscal impact, the primary cost drivers, and common population characteristics of recipients with needs that cannot be met by the framework rates.

(m) No later than July 1, 2016, the commissioner shall develop and implement, in consultation with stakeholders, a process to determine eligibility for rate exceptions for individuals with rates determined under the methodology in section 256B.4913, subdivision 4a. Determination of eligibility for an exception will occur as annual service renewals are completed.

(n) Approved rate exceptions will be implemented at such time that the individual's rate is no longer banded and remain in effect in all cases until an individual's needs change as defined in paragraph (c).

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

Sec. 19. Minnesota Statutes 2018, section 256B.85, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Activities of daily living" or "ADLs" means ~~eating, toileting, grooming, dressing, bathing, mobility, positioning, and transferring.~~ :

(1) dressing, including assistance with choosing, application, and changing of clothing and application of special appliances, wraps, or clothing;

(2) grooming, including assistance with basic hair care, oral care, shaving, applying cosmetics and deodorant, and care of eyeglasses and hearing aids. Nail care is included, except for recipients who are diabetic or have poor circulation;

(3) bathing, including assistance with basic personal hygiene and skin care;

(4) eating, including assistance with hand washing and application of orthotics required for eating, transfers, or feeding;

(5) transfers, including assistance with transferring the recipient from one seating or reclining area to another;

(6) mobility, including assistance with ambulation and use of a wheelchair. Mobility does not include providing transportation for a recipient;

(7) positioning, including assistance with positioning or turning a recipient for necessary care and comfort; and

(8) toileting, including assistance with bowel or bladder elimination and care, transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and adjusting clothing.

(c) "Agency-provider model" means a method of CFSS under which a qualified agency provides services and supports through the agency's own employees and policies. The agency must allow the participant to have a significant role in the selection and dismissal of support workers of their choice for the delivery of their specific services and supports.

(d) "Behavior" means a description of a need for services and supports used to determine the home care rating and additional service units. The presence of Level I behavior is used to determine the home care rating.

(e) "Budget model" means a service delivery method of CFSS that allows the use of a service budget and assistance from a financial management services (FMS) provider for a participant to directly employ support workers and purchase supports and goods.

(f) "Complex health-related needs" means an intervention listed in clauses (1) to (8) that has been ordered by a physician, and is specified in a community services and support plan, including:

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

(ii) continuous tube feeding lasting longer than 12 hours per day;

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

(iii) requiring sterile or clean dressing changes or a wound vac; or

(iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized care;

(3) parenteral therapy described as:

(i) IV therapy more than two times per week lasting longer than four hours for each treatment; or

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

(i) oxygen required more than eight hours per day;

(ii) respiratory vest more than one time per day;

(iii) bronchial drainage treatments more than two times per day;

(iv) sterile or clean suctioning more than six times per day;

(v) dependence on another to apply respiratory ventilation augmentation devices such as BiPAP and CPAP; and

(vi) ventilator dependence under section 256B.0651;

(5) insertion and maintenance of catheter, including:

(i) sterile catheter changes more than one time per month;

(ii) clean intermittent catheterization, and including self-catheterization more than six times per day; or

(iii) bladder irrigations;

(6) bowel program more than two times per week requiring more than 30 minutes to perform each time;

(7) neurological intervention, including:

(i) seizures more than two times per week and requiring significant physical assistance to maintain safety; or

(ii) swallowing disorders diagnosed by a physician and requiring specialized assistance from another on a daily basis; and

(8) other congenital or acquired diseases creating a need for significantly increased direct hands-on assistance and interventions in six to eight activities of daily living.

(g) "Community first services and supports" or "CFSS" means the assistance and supports program under this section needed for accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task, or the purchase of goods as defined in subdivision 7, clause (3), that replace the need for human assistance.

(h) "Community first services and supports service delivery plan" or "CFSS service delivery plan" means a written document detailing the services and supports chosen by the participant to meet assessed needs that are within the approved CFSS service authorization,

as determined in subdivision 8. Services and supports are based on the coordinated service and support plan identified in ~~section~~ sections 256B.0915, subdivision 6, and 256B.092, subdivision 1b.

(i) "Consultation services" means a Minnesota health care program enrolled provider organization that provides assistance to the participant in making informed choices about CFSS services in general and self-directed tasks in particular, and in developing a person-centered CFSS service delivery plan to achieve quality service outcomes.

(j) "Critical activities of daily living" means transferring, mobility, eating, and toileting.

(k) "Dependency" in activities of daily living means a person requires hands-on assistance or constant supervision and cueing to accomplish one or more of the activities of daily living every day or on the days during the week that the activity is performed; however, a child may not be found to be dependent in an activity of daily living if, because of the child's age, an adult would either perform the activity for the child or assist the child with the activity and the assistance needed is the assistance appropriate for a typical child of the same age.

(l) "Extended CFSS" means CFSS services and supports provided under CFSS that are included in the CFSS service delivery plan through one of the home and community-based services waivers and as approved and authorized under sections 256B.0915; 256B.092, subdivision 5; and 256B.49, which exceed the amount, duration, and frequency of the state plan CFSS services for participants. Extended CFSS excludes the purchase of goods.

(m) "Financial management services provider" or "FMS provider" means a qualified organization required for participants using the budget model under subdivision 13 that is an enrolled provider with the department to provide vendor fiscal/employer agent financial management services (FMS).

(n) "Health-related procedures and tasks" means procedures and tasks related to the specific assessed health needs of a participant that can be taught or assigned by a state-licensed health care or mental health professional and performed by a support worker.

(o) "Instrumental activities of daily living" means activities related to living independently in the community, including but not limited to: meal planning, preparation, and cooking; shopping for food, clothing, or other essential items; laundry; housecleaning; assistance with medications; managing finances; communicating needs and preferences during activities; arranging supports; and assistance with traveling around and participating in the community.

(p) "Lead agency" has the meaning given in section 256B.0911, subdivision 1a, paragraph (e).

(q) "Legal representative" means parent of a minor, a court-appointed guardian, or another representative with legal authority to make decisions about services and supports for the participant. Other representatives with legal authority to make decisions include but are not limited to a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

(r) "Level I behavior" means physical aggression towards self or others or destruction of property that requires the immediate response of another person.

(s) "Medication assistance" means providing verbal or visual reminders to take regularly scheduled medication, and includes any of the following supports listed in clauses (1) to (3) and other types of assistance, except that a support worker may not determine medication dose or time for medication or inject medications into veins, muscles, or skin:

(1) under the direction of the participant or the participant's representative, bringing medications to the participant including medications given through a nebulizer, opening a container of previously set-up medications, emptying the container into the participant's hand, opening and giving the medication in the original container to the participant, or bringing to the participant liquids or food to accompany the medication;

(2) organizing medications as directed by the participant or the participant's representative; and

(3) providing verbal or visual reminders to perform regularly scheduled medications.

(t) "Participant" means a person who is eligible for CFSS.

(u) "Participant's representative" means a parent, family member, advocate, or other adult authorized by the participant or participant's legal representative, if any, to serve as a representative in connection with the provision of CFSS. ~~This authorization must be in writing or by another method that clearly indicates the participant's free choice and may be withdrawn at any time. The participant's representative must have no financial interest in the provision of any services included in the participant's CFSS service delivery plan and must be capable of providing the support necessary to assist the participant in the use of CFSS. If through the assessment process described in subdivision 5 a participant is determined to be in need of a participant's representative, one must be selected.~~ If the participant is unable to assist in the selection of a participant's representative, the legal representative shall appoint one. ~~Two persons may be designated as a participant's representative for reasons such as divided households and court-ordered custodies. Duties of a participant's representatives may include:~~

~~(1) being available while services are provided in a method agreed upon by the participant or the participant's legal representative and documented in the participant's CFSS service delivery plan;~~

~~(2) monitoring CFSS services to ensure the participant's CFSS service delivery plan is being followed; and~~

~~(3) reviewing and signing CFSS time sheets after services are provided to provide verification of the CFSS services.~~

(v) "Person-centered planning process" means a process that is directed by the participant to plan for CFSS services and supports.

(w) "Service budget" means the authorized dollar amount used for the budget model or for the purchase of goods.

(x) "Shared services" means the provision of CFSS services by the same CFSS support worker to two or three participants who voluntarily enter into an agreement to receive services at the same time and in the same setting by the same employer.

(y) "Support worker" means a qualified and trained employee of the agency-provider as required by subdivision 11b or of the participant employer under the budget model as required by subdivision 14 who has direct contact with the participant and provides services as specified within the participant's CFSS service delivery plan.

(z) "Unit" means the increment of service based on hours or minutes identified in the service agreement.

(aa) "Vendor fiscal employer agent" means an agency that provides financial management services.

(bb) "Wages and benefits" means the hourly wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, contributions to employee retirement accounts, or other forms of employee compensation and benefits.

(cc) "Worker training and development" means services provided according to subdivision 18a for developing workers' skills as required by the participant's individual CFSS service delivery plan that are arranged for or provided by the agency-provider or purchased by the participant employer. These services include training, education, direct observation and supervision, and evaluation and coaching of job skills and tasks, including supervision of health-related tasks or behavioral supports.

Sec. 20. Minnesota Statutes 2018, section 256B.85, subdivision 4, is amended to read:

Subd. 4. **Eligibility for other services.** Selection of CFSS by a participant must not restrict access to other medically necessary care and services furnished under the state plan benefit or other services available through the alternative care program.

Sec. 21. Minnesota Statutes 2018, section 256B.85, subdivision 5, is amended to read:

Subd. 5. **Assessment requirements.** (a) The assessment of functional need must:

(1) be conducted by a certified assessor according to the criteria established in section 256B.0911, subdivision 3a;

(2) be conducted face-to-face, initially and at least annually thereafter, or when there is a significant change in the participant's condition or a change in the need for services and supports, or at the request of the participant when the participant experiences a change in condition or needs a change in the services or supports; and

(3) be completed using the format established by the commissioner.

(b) The results of the assessment and any recommendations and authorizations for CFSS must be determined and communicated in writing by the lead agency's ~~certified~~ assessor as defined in section 256B.0911 to the participant ~~and the agency-provider or FMS provider chosen by the participant~~ or participant's representative and chosen CFSS providers within ~~40 calendar~~ ten business days ~~and must include the participant's right to appeal under section 256.045, subdivision 3~~ of the assessment.

(c) The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model. Authorization for a temporary level of CFSS services under the agency-provider model is limited to the time specified by the commissioner, but shall not exceed 45 days. The level of services authorized under this paragraph shall have no bearing on a future authorization.

For CFSS services beyond the temporary authorization, participants ~~approved for a temporary authorization~~ shall access the consultation service to complete their orientation and selection of a service model.

Sec. 22. Minnesota Statutes 2018, section 256B.85, subdivision 6, is amended to read:

Subd. 6. **Community first services and supports service delivery plan.** (a) The CFSS service delivery plan must be developed and evaluated through a person-centered planning process by the participant, or the participant's representative or legal representative who

may be assisted by a consultation services provider. The CFSS service delivery plan must reflect the services and supports that are important to the participant and for the participant to meet the needs assessed by the certified assessor and identified in the coordinated service and support plan identified in ~~section~~ sections 256B.0915, subdivision 6, and 256B.092, subdivision 1b. The CFSS service delivery plan must be reviewed by the participant, the consultation services provider, and the agency-provider or FMS provider prior to starting services and at least annually upon reassessment, or when there is a significant change in the participant's condition, or a change in the need for services and supports.

(b) The commissioner shall establish the format and criteria for the CFSS service delivery plan.

(c) The CFSS service delivery plan must be person-centered and:

(1) specify the consultation services provider, agency-provider, or FMS provider selected by the participant;

(2) reflect the setting in which the participant resides that is chosen by the participant;

(3) reflect the participant's strengths and preferences;

(4) include the methods and supports used to address the needs as identified through an assessment of functional needs;

(5) include the participant's identified goals and desired outcomes;

(6) reflect the services and supports, paid and unpaid, that will assist the participant to achieve identified goals, including the costs of the services and supports, and the providers of those services and supports, including natural supports;

(7) identify the amount and frequency of face-to-face supports and amount and frequency of remote supports and technology that will be used;

(8) identify risk factors and measures in place to minimize them, including individualized backup plans;

(9) be understandable to the participant and the individuals providing support;

(10) identify the individual or entity responsible for monitoring the plan;

(11) be finalized and agreed to in writing by the participant and signed by ~~all~~ individuals and providers responsible for its implementation;

(12) be distributed to the participant and other people involved in the plan;

(13) prevent the provision of unnecessary or inappropriate care;

(14) include a detailed budget for expenditures for budget model participants or participants under the agency-provider model if purchasing goods; and

(15) include a plan for worker training and development provided according to subdivision 18a detailing what service components will be used, when the service components will be used, how they will be provided, and how these service components relate to the participant's individual needs and CFSS support worker services.

(d) The CFSS service delivery plan must describe the units or dollar amount available to the participant. The total units of agency-provider services or the service budget amount for the budget model include both annual totals and a monthly average amount that cover the number of months of the service agreement. The amount used each month may vary, but additional funds must not be provided above the annual service authorization amount, determined according to subdivision 8, unless a change in condition is assessed and authorized by the certified assessor and documented in the coordinated service and support plan and CFSS service delivery plan.

(e) In assisting with the development or modification of the CFSS service delivery plan during the authorization time period, the consultation services provider shall:

(1) consult with the FMS provider on the spending budget when applicable; and

(2) consult with the participant or participant's representative, agency-provider, and case manager/care coordinator.

(f) The CFSS service delivery plan must be approved by the consultation services provider for participants without a case manager or care coordinator who is responsible for authorizing services. A case manager or care coordinator must approve the plan for a waiver or alternative care program participant.

Sec. 23. Minnesota Statutes 2018, section 256B.85, subdivision 8, is amended to read:

Subd. 8. **Determination of CFSS service authorization amount.** (a) All community first services and supports must be authorized by the commissioner or the commissioner's designee before services begin. The authorization for CFSS must be completed as soon as possible following an assessment but no later than 40 calendar days from the date of the assessment.

(b) The amount of CFSS authorized must be based on the participant's home care rating described in paragraphs (d) and (e) and any additional service units for which the participant qualifies as described in paragraph (f).

(c) The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner identifying the following for a participant:

(1) the total number of dependencies of activities of daily living;

(2) the presence of complex health-related needs; and

(3) the presence of Level I behavior.

(d) The methodology to determine the total service units for CFSS for each home care rating is based on the median paid units per day for each home care rating from fiscal year 2007 data for the PCA program.

(e) Each home care rating is designated by the letters P through Z and EN and has the following base number of service units assigned:

(1) P home care rating requires Level I behavior or one to three dependencies in ADLs and qualifies the person for five service units;

(2) Q home care rating requires Level I behavior and one to three dependencies in ADLs and qualifies the person for six service units;

(3) R home care rating requires a complex health-related need and one to three dependencies in ADLs and qualifies the person for seven service units;

(4) S home care rating requires four to six dependencies in ADLs and qualifies the person for ten service units;

(5) T home care rating requires four to six dependencies in ADLs and Level I behavior and qualifies the person for 11 service units;

(6) U home care rating requires four to six dependencies in ADLs and a complex health-related need and qualifies the person for 14 service units;

(7) V home care rating requires seven to eight dependencies in ADLs and qualifies the person for 17 service units;

(8) W home care rating requires seven to eight dependencies in ADLs and Level I behavior and qualifies the person for 20 service units;

(9) Z home care rating requires seven to eight dependencies in ADLs and a complex health-related need and qualifies the person for 30 service units; and

(10) EN home care rating includes ventilator dependency as defined in section 256B.0651, subdivision 1, paragraph (g). A person who meets the definition of ventilator-dependent

and the EN home care rating and utilize a combination of CFSS and home care nursing services is limited to a total of 96 service units per day for those services in combination. Additional units may be authorized when a person's assessment indicates a need for two staff to perform activities. Additional time is limited to 16 service units per day.

(f) Additional service units are provided through the assessment and identification of the following:

(1) 30 additional minutes per day for a dependency in each critical activity of daily living;

(2) 30 additional minutes per day for each complex health-related need; and

(3) ~~30 additional minutes per day when the behavior requires assistance at least four times per week for one or more of the following behaviors~~ 30 additional minutes per day for each behavior under this clause that requires assistance at least four times per week:

(i) level I behavior that requires the immediate response of another person;

(ii) increased vulnerability due to cognitive deficits or socially inappropriate behavior; or

(iii) increased need for assistance for participants who are verbally aggressive or resistive to care so that the time needed to perform activities of daily living is increased.

(g) The service budget for budget model participants shall be based on:

(1) assessed units as determined by the home care rating; and

(2) an adjustment needed for administrative expenses.

Sec. 24. Minnesota Statutes 2018, section 256B.85, subdivision 9, is amended to read:

Subd. 9. **Noncovered services.** (a) Services or supports that are not eligible for payment under this section include those that:

(1) are not authorized by the certified assessor or included in the CFSS service delivery plan;

(2) are provided prior to the authorization of services and the approval of the CFSS service delivery plan;

(3) are duplicative of other paid services in the CFSS service delivery plan;

(4) supplant natural unpaid supports that appropriately meet a need in the CFSS service delivery plan, are provided voluntarily to the participant, and are selected by the participant in lieu of other services and supports;

(5) are not effective means to meet the participant's needs; and

(6) are available through other funding sources, including, but not limited to, funding through title IV-E of the Social Security Act.

(b) Additional services, goods, or supports that are not covered include:

(1) those that are not for the direct benefit of the participant, except that services for caregivers such as training to improve the ability to provide CFSS are considered to directly benefit the participant if chosen by the participant and approved in the support plan;

(2) any fees incurred by the participant, such as Minnesota health care programs fees and co-pays, legal fees, or costs related to advocate agencies;

(3) insurance, except for insurance costs related to employee coverage;

(4) room and board costs for the participant;

(5) services, supports, or goods that are not related to the assessed needs;

(6) special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services provided under the Rehabilitation Act of 1973;

(7) assistive technology devices and assistive technology services other than those for back-up systems or mechanisms to ensure continuity of service and supports listed in subdivision 7;

(8) medical supplies and equipment covered under medical assistance;

(9) environmental modifications, except as specified in subdivision 7;

(10) expenses for travel, lodging, or meals related to training the participant or the participant's representative or legal representative;

(11) experimental treatments;

(12) any service or good covered by other state plan services, including prescription and over-the-counter medications, compounds, and solutions and related fees, including premiums and co-payments;

(13) membership dues or costs, except when the service is necessary and appropriate to treat a health condition or to improve or maintain the adult participant's health condition.

The condition must be identified in the participant's CFSS service delivery plan and monitored by a Minnesota health care program enrolled physician;

(14) vacation expenses other than the cost of direct services;

(15) vehicle maintenance or modifications not related to the disability, health condition, or physical need;

(16) tickets and related costs to attend sporting or other recreational or entertainment events;

(17) services provided and billed by a provider who is not an enrolled CFSS provider;

(18) CFSS provided by a participant's representative or paid legal guardian;

(19) services that are used solely as a child care or babysitting service;

(20) services that are the responsibility or in the daily rate of a residential or program license holder under the terms of a service agreement and administrative rules;

(21) sterile procedures;

(22) giving of injections into veins, muscles, or skin;

(23) homemaker services that are not an integral part of the assessed CFSS service;

(24) home maintenance or chore services;

(25) home care services, including hospice services if elected by the participant, covered by Medicare or any other insurance held by the participant;

(26) services to other members of the participant's household;

(27) services not specified as covered under medical assistance as CFSS;

(28) application of restraints or implementation of deprivation procedures;

(29) assessments by CFSS provider organizations or by independently enrolled registered nurses;

(30) services provided in lieu of legally required staffing in a residential or child care setting; ~~and~~

(31) services provided ~~by the residential or program license holder in a residence for more than four participants.~~ in licensed foster care, except when:

(i) the foster care home is the foster care license holder's primary residence; or

(ii) the licensed capacity is four or fewer, or all conditions for a variance under Minnesota Rules, part 2960.3030, subpart 3, are met for a group of siblings, as defined in section 260C.007, subdivision 32;

(32) services from a provider who owns or otherwise controls for the living arrangement, except when the provider of services is related by blood, marriage, or adoption or when the provider meets the requirements under clause (31); and

(33) instrumental activities of daily living for children younger than 18 years of age, except when immediate attention is needed for health or hygiene reasons integral to the personal care services and the assessor lists the need in the service plan.

Sec. 25. Minnesota Statutes 2018, section 256B.85, subdivision 10, is amended to read:

Subd. 10. **Agency-provider and FMS provider qualifications and duties.** (a) Agency-providers identified in subdivision 11 and FMS providers identified in subdivision 13a shall:

(1) enroll as a medical assistance Minnesota health care programs provider and meet all applicable provider standards and requirements including completion of required provider training as determined by the commissioner;

(2) demonstrate compliance with federal and state laws and policies for CFSS as determined by the commissioner;

(3) comply with background study requirements under chapter 245C and maintain documentation of background study requests and results;

(4) verify and maintain records of all services and expenditures by the participant, including hours worked by support workers;

(5) not engage in any agency-initiated direct contact or marketing in person, by telephone, or other electronic means to potential participants, guardians, family members, or participants' representatives;

(6) directly provide services and not use a subcontractor or reporting agent;

(7) meet the financial requirements established by the commissioner for financial solvency;

(8) have never had a lead agency contract or provider agreement discontinued due to fraud, or have never had an owner, board member, or manager fail a state or FBI-based criminal background check while enrolled or seeking enrollment as a Minnesota health care programs provider; and

(9) have an office located in Minnesota.

(b) In conducting general duties, agency-providers and FMS providers shall:

(1) pay support workers based upon actual hours of services provided;

(2) pay for worker training and development services based upon actual hours of services provided or the unit cost of the training session purchased;

(3) withhold and pay all applicable federal and state payroll taxes;

(4) make arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

(5) enter into a written agreement with the participant, participant's representative, or legal representative that assigns roles and responsibilities to be performed before services, supports, or goods are provided;

(6) report maltreatment as required under sections 626.556 and 626.557; ~~and~~

(7) comply with any data requests from the department consistent with the Minnesota Government Data Practices Act under chapter 13~~.~~; and

(8) request reassessments at least 60 days before the end of the current authorization for CFSS on forms provided by the commissioner.

Sec. 26. Minnesota Statutes 2018, section 256B.85, subdivision 11, is amended to read:

Subd. 11. **Agency-provider model.** (a) The agency-provider model includes services provided by support workers and staff providing worker training and development services who are employed by an agency-provider that meets the criteria established by the commissioner, including required training.

(b) The agency-provider shall allow the participant to have a significant role in the selection and dismissal of the support workers for the delivery of the services and supports specified in the participant's CFSS service delivery plan. The agency must make a reasonable effort to fulfill the participant's request for the participant's preferred worker.

(c) A participant may use authorized units of CFSS services as needed within a service agreement that is not greater than 12 months. Using authorized units in a flexible manner in either the agency-provider model or the budget model does not increase the total amount of services and supports authorized for a participant or included in the participant's CFSS service delivery plan.

(d) A participant may share CFSS services. Two or three CFSS participants may share services at the same time provided by the same support worker.

(e) The agency-provider must use a minimum of 72.5 percent of the revenue generated by the medical assistance payment for CFSS for support worker wages and benefits. The agency-provider must document how this requirement is being met. The revenue generated by the worker training and development services and the reasonable costs associated with the worker training and development services must not be used in making this calculation.

(f) The agency-provider model must be used by individuals who are restricted by the Minnesota restricted recipient program under Minnesota Rules, parts 9505.2160 to 9505.2245.

(g) Participants purchasing goods under this model, along with support worker services, must:

(1) specify the goods in the CFSS service delivery plan and detailed budget for expenditures that must be approved by the consultation services provider, case manager, or care coordinator; and

(2) use the FMS provider for the billing and payment of such goods.

Sec. 27. Minnesota Statutes 2018, section 256B.85, subdivision 11b, is amended to read:

Subd. 11b. **Agency-provider model; support worker competency.** (a) The agency-provider must ensure that support workers are competent to meet the participant's assessed needs, goals, and additional requirements as written in the CFSS service delivery plan. Within 30 days of any support worker beginning to provide services for a participant, the agency-provider must evaluate the competency of the worker through direct observation of the support worker's performance of the job functions in a setting where the participant is using CFSS.

(b) The agency-provider must verify and maintain evidence of support worker competency, including documentation of the support worker's:

(1) education and experience relevant to the job responsibilities assigned to the support worker and the needs of the participant;

(2) relevant training received from sources other than the agency-provider;

(3) orientation and instruction to implement services and supports to participant needs and preferences as identified in the CFSS service delivery plan; ~~and~~

(4) orientation and instruction delivered by an individual competent to perform, teach, or assign the health-related tasks for tracheostomy suctioning and services to participants on ventilator support, including equipment operation and maintenance; and

(5) periodic performance reviews completed by the agency-provider at least annually, including any evaluations required under subdivision 11a, paragraph (a).

If a support worker is a minor, all evaluations of worker competency must be completed in person and in a setting where the participant is using CFSS.

(c) The agency-provider must develop a worker training and development plan with the participant to ensure support worker competency. The worker training and development plan must be updated when:

(1) the support worker begins providing services;

(2) there is any change in condition or a modification to the CFSS service delivery plan; or

(3) a performance review indicates that additional training is needed.

Sec. 28. Minnesota Statutes 2018, section 256B.85, subdivision 12, is amended to read:

Subd. 12. **Requirements for enrollment of CFSS agency-providers.** (a) All CFSS agency-providers must provide, at the time of enrollment, reenrollment, and revalidation as a CFSS agency-provider in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the CFSS agency-provider's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage. Upon new enrollment, or if the agency-provider's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the agency-provider must purchase a surety bond of $50,000. If the agency-provider's Medicaid revenue in the previous calendar year is greater than $300,000, the agency-provider must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(3) proof of fidelity bond coverage in the amount of $20,000 per provider location;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a ~~description~~ copy of the CFSS agency-provider's ~~organization~~ organizational chart identifying the names and roles of all owners, managing employees, staff, board of directors, and ~~the~~ additional documentation reporting any affiliations of the directors and owners to other service providers;

(7) ~~a copy of~~ proof that the CFSS ~~agency-provider's~~ agency-provider has written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety, including the process for notification and resolution of participant grievances, incident response, identification and prevention of communicable diseases, and employee misconduct;

(8) ~~copies of all other forms~~ proof that the CFSS agency-provider ~~uses in the course of daily business~~ has all of the following forms and documents including, but not limited to:

(i) a copy of the CFSS agency-provider's time sheet; and

(ii) a copy of the participant's individual CFSS service delivery plan;

(9) a list of all training and classes that the CFSS agency-provider requires of its staff providing CFSS services;

(10) documentation that the CFSS agency-provider and staff have successfully completed all the training required by this section;

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

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

(13) documentation that the agency-provider will use at least the following percentages of revenue generated from the medical assistance rate paid for CFSS services for CFSS support worker wages and benefits: 72.5 percent of revenue from CFSS providers. The revenue generated by the worker training and development services and the reasonable costs associated with the worker training and development services shall not be used in making this calculation; and

(14) documentation that the agency-provider does not burden participants' free exercise of their right to choose service providers by requiring CFSS support workers to sign an agreement not to work with any particular CFSS participant or for another CFSS agency-provider after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) CFSS agency-providers shall provide to the commissioner the information specified in paragraph (a).

(c) All CFSS agency-providers shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a CFSS agency-provider do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. CFSS agency-provider billing staff shall complete training about CFSS program financial management. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency.

~~(d) The commissioner shall send annual review notifications to agency-providers 30 days prior to renewal. The notification must:~~

~~(1) list the materials and information the agency-provider is required to submit;~~

~~(2) provide instructions on submitting information to the commissioner; and~~

~~(3) provide a due date by which the commissioner must receive the requested information.~~

Agency-providers shall submit all required documentation for annual review within 30 days of notification from the commissioner. If an agency-provider fails to submit all the required documentation, the commissioner may take action under subdivision 23a.

Sec. 29. Minnesota Statutes 2018, section 256B.85, subdivision 12b, is amended to read:

Subd. 12b. **CFSS agency-provider requirements; notice regarding termination of services.** (a) An agency-provider must provide written notice when it intends to terminate services with a participant at least ~~ten~~ 30 calendar days before the proposed service termination is to become effective, except in cases where:

(1) the participant engages in conduct that significantly alters the terms of the CFSS service delivery plan with the agency-provider;

(2) the participant or other persons at the setting where services are being provided engage in conduct that creates an imminent risk of harm to the support worker or other agency-provider staff; or

(3) an emergency or a significant change in the participant's condition occurs within a 24-hour period that results in the participant's service needs exceeding the participant's identified needs in the current CFSS service delivery plan so that the agency-provider cannot safely meet the participant's needs.

(b) When a participant initiates a request to terminate CFSS services with the agency-provider, the agency-provider must give the participant a written ~~acknowledgement~~ acknowledgment of the participant's service termination request that includes the date the request was received by the agency-provider and the requested date of termination.

(c) The agency-provider must participate in a coordinated transfer of the participant to a new agency-provider to ensure continuity of care.

Sec. 30. Minnesota Statutes 2018, section 256B.85, subdivision 13a, is amended to read:

Subd. 13a. **Financial management services.** (a) Services provided by an FMS provider include but are not limited to: filing and payment of federal and state payroll taxes on behalf of the participant; initiating and complying with background study requirements under chapter 245C and maintaining documentation of background study requests and results; billing for approved CFSS services with authorized funds; monitoring expenditures; accounting for and disbursing CFSS funds; providing assistance in obtaining and filing for liability, workers' compensation, and unemployment coverage; and providing participant instruction and technical assistance to the participant in fulfilling employer-related requirements in accordance with section 3504 of the Internal Revenue Code and related regulations and interpretations, including Code of Federal Regulations, title 26, section 31.3504-1.

(b) Agency-provider services shall not be provided by the FMS provider.

(c) The FMS provider shall provide service functions as determined by the commissioner for budget model participants that include but are not limited to:

(1) assistance with the development of the detailed budget for expenditures portion of the CFSS service delivery plan as requested by the consultation services provider or participant;

(2) data recording and reporting of participant spending;

(3) other duties established by the department, including with respect to providing assistance to the participant, participant's representative, or legal representative in performing employer responsibilities regarding support workers. The support worker shall not be considered the employee of the FMS provider; and

(4) billing, payment, and accounting of approved expenditures for goods.

(d) The FMS provider shall obtain an assurance statement from the participant employer agreeing to follow state and federal regulations and CFSS policies regarding employment of support workers.

(e) The FMS provider shall:

(1) not limit or restrict the participant's choice of service or support providers or service delivery models consistent with any applicable state and federal requirements;

(2) provide the participant, consultation services provider, and case manager or care coordinator, if applicable, with a monthly written summary of the spending for services and supports that were billed against the spending budget;

(3) be knowledgeable of state and federal employment regulations, including those under the Fair Labor Standards Act of 1938, and comply with the requirements under section 3504 of the Internal Revenue Code and related regulations and interpretations, including Code of Federal Regulations, title 26, section 31.3504-1, regarding agency employer tax liability for vendor fiscal/employer agent, and any requirements necessary to process employer and employee deductions, provide appropriate and timely submission of employer tax liabilities, and maintain documentation to support medical assistance claims;

(4) have current and adequate liability insurance and bonding and sufficient cash flow as determined by the commissioner and have on staff or under contract a certified public accountant or an individual with a baccalaureate degree in accounting;

(5) assume fiscal accountability for state funds designated for the program and be held liable for any overpayments or violations of applicable statutes or rules, including but not limited to the Minnesota False Claims Act, chapter 15C; ~~and~~

(6) maintain documentation of receipts, invoices, and bills to track all services and supports expenditures for any goods purchased and maintain time records of support workers. The documentation and time records must be maintained for a minimum of five years from the claim date and be available for audit or review upon request by the commissioner. Claims submitted by the FMS provider to the commissioner for payment must correspond with services, amounts, and time periods as authorized in the participant's service budget and service plan and must contain specific identifying information as determined by the commissioner~~.~~; and

(7) provide written notice to the participant or the participant's representative at least 30 calendar days before a proposed service termination becomes effective.

(f) The commissioner of human services shall:

(1) establish rates and payment methodology for the FMS provider;

(2) identify a process to ensure quality and performance standards for the FMS provider and ensure statewide access to FMS providers; and

(3) establish a uniform protocol for delivering and administering CFSS services to be used by eligible FMS providers.

Sec. 31. Minnesota Statutes 2018, section 256B.85, is amended by adding a subdivision to read:

Subd. 14a. **Participant's representative responsibilities.** (a) If a participant is unable to direct the participant's own care, the participant must use a participant's representative to receive CFSS services. A participant's representative is required if:

(1) the person is under 18 years of age;

(2) the person has a court-appointed guardian; or

(3) an assessment according to section 256B.0659, subdivision 3a, determines that the participant is in need of a participant's representative.

(b) A participant's representative must:

(1) be at least 18 years of age and actively participate in planning and directing CFSS services;

(2) have sufficient knowledge of the participant's circumstances to use CFSS services consistent with the participant's health and safety needs identified in the participant's care plan;

(3) not have a financial interest in the provision of any services included in the participant's CFSS service delivery plan; and

(4) be capable of providing the support necessary to assist the participant in the use of CFSS services.

(c) A participant's representative must not be the:

(1) support worker;

(2) worker training and development service provider;

(3) agency-provider staff, unless related to the participant by blood, marriage, or adoption;

(4) consultation service provider, unless related to the participant by blood, marriage, or adoption;

(5) FMS staff, unless related to the participant by blood, marriage, or adoption;

(6) FMS owner or manager; or

(7) lead agency staff acting as part of employment.

(d) A licensed family foster parent who lives with the participant may be the participant's representative if the family foster parent meets the other participant's representative requirements.

(e) There may be two persons designated as the participant's representative, including instances of divided households and court-ordered custodies. Each person named as participant's representative must meet the program criteria and responsibilities.

(f) The participant or the participant's legal representative shall appoint a participant's representative. The participant's file must include written documentation that indicates the participant's free choice. The participant's representative must be identified at the time of assessment and listed on the participant's service agreement and CFSS service delivery plan.

(g) A participant's representative shall enter into a written agreement with an agency-provider or FMS, on a form determined by the commissioner, to:

(1) be available while care is provided in a method agreed upon by the participant or the participant's legal representative and documented in the participant's service delivery plan;

(2) monitor CFSS services to ensure the participant's service delivery plan is followed;

(3) review and sign support worker time sheets after services are provided to verify the provision of services;

(4) review and sign vendor paperwork to verify receipt of the good; and

(5) review and sign documentation to verify worker training after receipt of the worker training.

(h) A participant's representative may delegate the responsibility to another adult who is not the support worker during a temporary absence of at least 24 hours but not more than six months. To delegate responsibility the participant's representative must:

(1) ensure that the delegate as the participant's representative satisfies the requirement of the participant's representative;

(2) ensure that the delegate performs the functions of the participant's representative;

(3) communicate to the CFSS agency-provider or FMS about the need for a delegate by updating the written agreement to include the name of the delegate and the delegate's contact information; and

(4) ensure that the delegate protects the participant's privacy according to federal and state data privacy laws.

(i) The designation of a participant's representative remains in place until:

(1) the participant revokes the designation;

(2) the participant's representative withdraws the designation or becomes unable to fulfill the duties;

(3) the legal authority to act as a participant's representative changes; or

(4) the participant's representative is disqualified.

(j) A lead agency may disqualify a participant's representative who engages in conduct that creates an imminent risk of harm to the participant, the support workers, or other staff. A participant's representative that fails to provide support required by the participant must be referred to the common entry point.

Sec. 32. Minnesota Statutes 2018, section 256B.85, subdivision 18a, is amended to read:

Subd. 18a. **Worker training and development services.** (a) The commissioner shall develop the scope of tasks and functions, service standards, and service limits for worker training and development services.

(b) Worker training and development costs are in addition to the participant's assessed service units or service budget. Services provided according to this subdivision must:

(1) help support workers obtain and expand the skills and knowledge necessary to ensure competency in providing quality services as needed and defined in the participant's CFSS service delivery plan and as required under subdivisions 11b and 14;

(2) be provided or arranged for by the agency-provider under subdivision 11, or purchased by the participant employer under the budget model as identified in subdivision 13; ~~and~~

(3) be delivered by an individual competent to perform, teach, or assign the tasks identified, including health-related tasks, in the plan through education, training, and work experience relevant to the person's assessed needs; and

(4) be described in the participant's CFSS service delivery plan and documented in the participant's file.

(c) Services covered under worker training and development shall include:

(1) support worker training on the participant's individual assessed needs and condition, provided individually or in a group setting by a skilled and knowledgeable trainer beyond any training the participant or participant's representative provides;

(2) tuition for professional classes and workshops for the participant's support workers that relate to the participant's assessed needs and condition;

(3) direct observation, monitoring, coaching, and documentation of support worker job skills and tasks, beyond any training the participant or participant's representative provides, including supervision of health-related tasks or behavioral supports that is conducted by an appropriate professional based on the participant's assessed needs. These services must be provided at the start of services or the start of a new support worker except as provided in paragraph (d) and must be specified in the participant's CFSS service delivery plan; and

(4) the activities to evaluate CFSS services and ensure support worker competency described in subdivisions 11a and 11b.

(d) The services in paragraph (c), clause (3), are not required to be provided for a new support worker providing services for a participant due to staffing failures, unless the support worker is expected to provide ongoing backup staffing coverage.

(e) Worker training and development services shall not include:

(1) general agency training, worker orientation, or training on CFSS self-directed models;

(2) payment for preparation or development time for the trainer or presenter;

(3) payment of the support worker's salary or compensation during the training;

(4) training or supervision provided by the participant, the participant's support worker, or the participant's informal supports, including the participant's representative; or

(5) services in excess of 96 units per annual service agreement, unless approved by the department.

Sec. 33. **REVISOR INSTRUCTION; CORRECTING TERMINOLOGY.**

(a) The revisor of statutes shall change the term "developmental disability waiver" or similar terms to "developmental disabilities waiver" or similar terms wherever they appear

in Minnesota Statutes. The revisor shall also make technical and other necessary changes to sentence structure to preserve the meaning of the text.

(b) In Minnesota Statutes, sections 256.01, subdivisions 2 and 24; 256.975, subdivision 7; 256B.0911, subdivisions 1a, 3b, and 4d; and 256B.439, subdivision 4, the revisor of statutes shall substitute the term "Disability Linkage Line" or similar terms for "Disability Hub" or similar terms. The revisor shall also make grammatical changes related to the changes in terms.

Sec. 34. **REVISOR INSTRUCTION; PCA TRANSITION TO CFSS.**

The revisor of statutes, in consultation with the House Research Department, Office of Senate Counsel, Research and Fiscal Analysis, and Department of Human Services, shall prepare legislation for the 2020 legislative session to repeal laws governing the consumer support grant program and personal care assistance program in Minnesota Statutes, chapters 256 and 256B, correct cross-references, remove obsolete language, and, as necessary, provide for the transition from the personal care assistance program to community first services and supports.

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