House Language H2128-4

ARTICLE 15

COMMUNITY SUPPORTS POLICY

Senate Language UEH2128-1

ARTICLE 15

COMMUNITY SUPPORTS POLICY

Section 1. Minnesota Statutes 2020, section 245.4874, subdivision 1, is amended to read:

Subdivision 1. **Duties of county board.** (a) The county board must:

(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4889;

(2) consider the assessment of unmet needs in the county as reported by the local children's mental health advisory council under section 245.4875, subdivision 5, paragraph (b), clause (3). The county shall provide, upon request of the local children's mental health advisory council, readily available data to assist in the determination of unmet needs;

(3) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4889;

(4) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to improve the availability of mental health services to children and the cost-effectiveness of their delivery;

(5) assure that mental health services delivered according to sections 245.487 to 245.4889 are delivered expeditiously and are appropriate to the child's diagnostic assessment and individual treatment plan;

(6) provide for case management services to each child with severe emotional disturbance according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881, subdivisions 1, 3, and 5;

(7) provide for screening of each child under section 245.4885 upon admission to a residential treatment facility, acute care hospital inpatient treatment, or informal admission to a regional treatment center;

(8) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4889;

(9) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract to the county to provide mental health services are qualified under section 245.4871;

(10) assure that children's mental health services are coordinated with adult mental health services specified in sections 245.461 to 245.486 so that a continuum of mental health services is available to serve persons with mental illness, regardless of the person's age;

(11) assure that culturally competent mental health consultants are used as necessary to assist the county board in assessing and providing appropriate treatment for children of cultural or racial minority heritage; and

(12) consistent with section 245.486, arrange for or provide a children's mental health screening for:

(i) a child receiving child protective services;

(ii) a child in out-of-home placement;

(iii) a child for whom parental rights have been terminated;

(iv) a child found to be delinquent; or

(v) a child found to have committed a juvenile petty offense for the third or subsequent time.

A children's mental health screening is not required when a screening or diagnostic assessment has been performed within the previous 180 days, or the child is currently under the care of a mental health professional.

(b) When a child is receiving protective services or is in out-of-home placement, the court or county agency must notify a parent or guardian whose parental rights have not been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county agency in writing.

(c) When a child is found to be delinquent or a child is found to have committed a juvenile petty offense for the third or subsequent time, the court or county agency must obtain written informed consent from the parent or legal guardian before a screening is conducted unless the court, notwithstanding the parent's failure to consent, determines that the screening is in the child's best interest.

(d) The screening shall be conducted with a screening instrument approved by the commissioner of human services according to criteria that are updated and issued annually to ensure that approved screening instruments are valid and useful for child welfare and juvenile justice populations. Screenings shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer or local social services agency staff person who is trained in the use of the screening instrument. Training in the use of the instrument shall include:

(1) training in the administration of the instrument;

(2) the interpretation of its validity given the child's current circumstances;

(3) the state and federal data practices laws and confidentiality standards;

(4) the parental consent requirement; and

(5) providing respect for families and cultural values.

If the screen indicates a need for assessment, the child's family, or if the family lacks mental health insurance, the local social services agency, in consultation with the child's family, shall have conducted a diagnostic assessment, including a functional assessment.

The administration of the screening shall safeguard the privacy of children receiving the screening and their families and shall comply with the Minnesota Government Data Practices Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Screening results ~~shall be considered private data and the commissioner shall not collect individual screening results~~ are classified as private data on individuals, as defined by section 13.02, subdivision 12. The county board or Tribal nation may provide the commissioner with access to the screening results for the purposes of program evaluation and improvement.

(e) When the county board refers clients to providers of children's therapeutic services and supports under section 256B.0943, the county board must clearly identify the desired services components not covered under section 256B.0943 and identify the reimbursement source for those requested services, the method of payment, and the payment rate to the provider.

Sec. 2. Minnesota Statutes 2020, section 245.697, subdivision 1, is amended to read:

Subdivision 1. **Creation.** (a) A State Advisory Council on Mental Health is created. The council must have members appointed by the governor in accordance with federal requirements. In making the appointments, the governor shall consider appropriate representation of communities of color. The council must be composed of:

(1) the assistant commissioner of ~~mental health for~~ the Department of Human Services who oversees behavioral health policy;

(2) a representative of the Department of Human Services responsible for the medical assistance program;

(3) a representative of the Department of Health;

~~(3)~~ (4) one member of each of the following professions:

(i) psychiatry;

(ii) psychology;

(iii) social work;

(iv) nursing;

(v) marriage and family therapy; and

(vi) professional clinical counseling;

~~(4)~~ (5) one representative from each of the following advocacy groups: Mental Health Association of Minnesota, NAMI-MN, ~~Mental Health Consumer/Survivor Network of Minnesota, and~~ Minnesota Disability Law Center, American Indian Mental Health Advisory Council, and a consumer-run mental health advocacy group;

~~(5)~~ (6) providers of mental health services;

~~(6)~~ (7) consumers of mental health services;

~~(7)~~ (8) family members of persons with mental illnesses;

~~(8)~~ (9) legislators;

~~(9)~~ (10) social service agency directors;

~~(10)~~ (11) county commissioners; and

~~(11)~~ (12) other members reflecting a broad range of community interests, including family physicians, or members as the United States Secretary of Health and Human Services may prescribe by regulation or as may be selected by the governor.

(b) The council shall select a chair. Terms, compensation, and removal of members and filling of vacancies are governed by section 15.059. Notwithstanding provisions of section 15.059, the council and its subcommittee on children's mental health do not expire. The commissioner of human services shall provide staff support and supplies to the council.

Sec. 3. Minnesota Statutes 2020, section 252.43, is amended to read:

252.43 COMMISSIONER'S DUTIES.

(a) The commissioner shall supervise lead agencies' provision of day services to adults with disabilities. The commissioner shall:

(1) determine the need for day ~~services~~ programs under ~~section~~ sections 256B.4914 and 252.41 to 252.46;

(2) establish payment rates as provided under section 256B.4914;

(3) adopt rules for the administration and provision of day services under sections 245A.01 to 245A.16~~,~~; 252.28, subdivision 2~~,~~; or 252.41 to 252.46~~,~~; or Minnesota Rules, parts 9525.1200 to 9525.1330;

(4) enter into interagency agreements necessary to ensure effective coordination and provision of day services;

(5) monitor and evaluate the costs and effectiveness of day services; and

(6) provide information and technical help to lead agencies and vendors in their administration and provision of day services.

(b) A determination of need in paragraph (a), clause (1), shall not be required for a change in day service provider name or ownership.

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

Sec. 4. Minnesota Statutes 2020, section 252A.01, subdivision 1, is amended to read:

Subdivision 1. **Policy.** (a) It is the policy of the state of Minnesota to provide a coordinated approach to the supervision, protection, and habilitation of its adult citizens with a developmental disability. In furtherance of this policy, sections 252A.01 to 252A.21 are enacted to authorize the commissioner of human services to:

(1) supervise those adult citizens with a developmental disability who are unable to fully provide for their own needs and for whom no qualified person is willing and able to seek guardianship ~~or conservatorship~~ under sections 524.5-101 to 524.5-502; and

(2) protect adults with a developmental disability from violation of their human and civil rights by ~~assuring~~ ensuring that they receive the full range of needed social, financial, residential, and habilitative services to which they are lawfully entitled.

(b) Public guardianship ~~or conservatorship~~ is the most restrictive form of guardianship ~~or conservatorship~~ and should be imposed only when ~~no other acceptable alternative is available~~ less restrictive alternatives have been attempted and determined to be insufficient to meet the person's needs. Less restrictive alternatives include but are not limited to supported decision making, community or residential services, or appointment of a health care agent.

Sec. 5. Minnesota Statutes 2020, section 252A.02, subdivision 2, is amended to read:

Subd. 2. **Person with a developmental disability.** "Person with a developmental disability" refers to any person age 18 or older who:

(1) has been diagnosed as having ~~significantly subaverage intellectual functioning existing concurrently with demonstrated deficits in adaptive behavior such as to require supervision and protection for the person's welfare or the public welfare.~~ a developmental disability;

(2) is impaired to the extent of lacking sufficient understanding or capacity to make personal decisions; and

(3) is unable to meet personal needs for medical care, nutrition, clothing, shelter, or safety, even with appropriate technological and supported decision-making assistance.

Sec. 6. Minnesota Statutes 2020, section 252A.02, subdivision 9, is amended to read:

Subd. 9. **~~Ward~~ Person subject to public guardianship.** ~~"Ward"~~ "Person subject to public guardianship" means a person with a developmental disability for whom the court has appointed a public guardian.

Sec. 7. Minnesota Statutes 2020, section 252A.02, subdivision 11, is amended to read:

Subd. 11. **Interested person.** "Interested person" means an interested responsible adult, ~~including, but not limited to, a public official, guardian, spouse, parent, adult sibling, legal~~

~~counsel, adult child, or next of kin of a person alleged to have a developmental disability.~~ including but not limited to:

(1) the person subject to guardianship, protected person, or respondent;

(2) a nominated guardian or conservator;

(3) a legal representative;

(4) the spouse; parent, including stepparent; adult children, including adult stepchildren of a living spouse; and siblings. If no such persons are living or can be located, the next of kin of the person subject to public guardianship or the respondent is an interested person;

(5) a representative of a state ombudsman's office or a federal protection and advocacy program that has notified the commissioner or lead agency that it has a matter regarding the protected person subject to guardianship, person subject to conservatorship, or respondent; and

(6) a health care agent or proxy appointed pursuant to a health care directive as defined in section 145C.01, subdivision 5a; a living will under chapter 145B; or other similar documentation executed in another state and enforceable under the laws of this state.

Sec. 8. Minnesota Statutes 2020, section 252A.02, subdivision 12, is amended to read:

Subd. 12. **Comprehensive evaluation.** (a) "Comprehensive evaluation" ~~shall consist~~ consists of:

(1) a medical report on the health status and physical condition of the proposed ~~ward,~~ person subject to public guardianship prepared under the direction of a licensed physician or advanced practice registered nurse;

(2) a report on the ~~proposed ward's~~ intellectual capacity and functional abilities~~, specifying~~ of the proposed person subject to public guardianship that specifies the tests and other data used in reaching its conclusions~~,~~ and is prepared by a psychologist who is qualified in the diagnosis of developmental disability; and

(3) a report from the case manager that includes:

(i) the most current assessment of ~~individual service~~ coordinated service and support needs as described in rules of the commissioner;

(ii) the most current individual service plan under section 256B.092, subdivision 1b; and

(iii) a description of contacts with and responses of near relatives of the proposed ~~ward~~ person subject to public guardianship notifying ~~them~~ the near relatives that a nomination for public guardianship has been made and advising ~~them~~ the near relatives that they may seek private guardianship.

(b) Each report under paragraph (a), clause (3), shall contain recommendations as to the amount of assistance and supervision required by the proposed ~~ward~~ person subject to public guardianship to function as independently as possible in society. To be considered part of the comprehensive evaluation, the reports must be completed no more than one year before filing the petition under section 252A.05.

Sec. 9. Minnesota Statutes 2020, section 252A.02, is amended by adding a subdivision to read:

Subd. 16. **Protected person.** "Protected person" means a person for whom a guardian or conservator has been appointed or other protective order has been sought. A protected person may be a minor.

Sec. 10. Minnesota Statutes 2020, section 252A.02, is amended by adding a subdivision to read:

Subd. 17. **Respondent.** "Respondent" means an individual for whom the appointment of a guardian or conservator or other protective order is sought.

Sec. 11. Minnesota Statutes 2020, section 252A.02, is amended by adding a subdivision to read:

Subd. 18. **Supported decision making.** "Supported decision making" means assistance to understand the nature and consequences of personal and financial decisions from one or more persons of the individual's choosing to enable the individual to make the personal and financial decisions and, when consistent with the individual's wishes, to communicate a decision once made.

Sec. 12. Minnesota Statutes 2020, section 252A.03, subdivision 3, is amended to read:

Subd. 3. **Standard for acceptance.** The commissioner shall accept the nomination if: ~~the comprehensive evaluation concludes that:~~

~~(1) the person alleged to have developmental disability is, in fact, developmentally disabled;~~ (1) the person's assessment confirms that they are a person with a developmental disability under section 252A.02, subdivision 2;

(2) the person is in need of the supervision and protection of a ~~conservator or~~ guardian; ~~and~~

(3) no qualified person is willing to assume guardianship ~~or conservatorship~~ under sections 524.5-101 to 524.5-502~~.~~; and

(4) the person subject to public guardianship was included in the process prior to the submission of the nomination.

Sec. 13. Minnesota Statutes 2020, section 252A.03, subdivision 4, is amended to read:

Subd. 4. **Alternatives.** (a) Public guardianship ~~or conservatorship~~ may be imposed only when:

(1) the person subject to guardianship is impaired to the extent of lacking sufficient understanding or capacity to make personal decisions;

(2) the person subject to guardianship is unable to meet personal needs for medical care, nutrition, clothing, shelter, or safety, even with appropriate technological and supported decision-making assistance; and

(3) no acceptable, less restrictive form of guardianship ~~or conservatorship~~ is available.

(b) The commissioner shall seek parents, near relatives, and other interested persons to assume guardianship for persons with developmental disabilities who are currently under public guardianship. If a person seeks to become a guardian ~~or conservator~~, costs to the person may be reimbursed under section 524.5-502. The commissioner must provide technical assistance to parents, near relatives, and interested persons seeking to become guardians ~~or conservators~~.

Sec. 14. Minnesota Statutes 2020, section 252A.04, subdivision 1, is amended to read:

Subdivision 1. **Local agency.** Upon receipt of a written nomination, the commissioner shall promptly order the local agency of the county in which the proposed ~~ward~~ person subject to public guardianship resides to coordinate or arrange for a comprehensive evaluation of the proposed ~~ward~~ person subject to public guardianship.

Sec. 15. Minnesota Statutes 2020, section 252A.04, subdivision 2, is amended to read:

Subd. 2. **Medication; treatment.** A proposed ~~ward~~ person subject to public guardianship who, at the time the comprehensive evaluation is to be performed, has been under medical care shall not be so under the influence or so suffer the effects of drugs, medication, or other treatment as to be hampered in the testing or evaluation process. When in the opinion of the licensed physician or advanced practice registered nurse attending the proposed ~~ward~~ person subject to public guardianship, the discontinuance of medication or other treatment is not in the ~~proposed ward's~~ best interest of the proposed person subject to public guardianship, the physician or advanced practice registered nurse shall record a list of all drugs, medication, or other treatment ~~which~~ that the proposed ~~ward~~ person subject to public guardianship received 48 hours immediately prior to any examination, test, or interview conducted in preparation for the comprehensive evaluation.

Sec. 16. Minnesota Statutes 2020, section 252A.04, subdivision 4, is amended to read:

Subd. 4. **File.** The comprehensive evaluation shall be kept on file at the Department of Human Services and shall be open to the inspection of the proposed ~~ward~~ person subject to public guardianship and ~~such~~ other persons ~~as may be given permission~~ permitted by the commissioner.

Sec. 17. Minnesota Statutes 2020, section 252A.05, is amended to read:

252A.05 COMMISSIONER'S PETITION FOR APPOINTMENT AS PUBLIC GUARDIAN ~~OR PUBLIC CONSERVATOR~~.

In every case in which the commissioner agrees to accept a nomination, the local agency, within 20 working days of receipt of the commissioner's acceptance, shall petition on behalf of the commissioner in the county or court of the county of residence of the person with a developmental disability for appointment to act as ~~public conservator or~~ public guardian of the person with a developmental disability.

Sec. 18. Minnesota Statutes 2020, section 252A.06, subdivision 1, is amended to read:

Subdivision 1. **Who may file.** ~~The commissioner, the local agency, a person with a developmental disability or any parent, spouse or relative of a person with a developmental disability may file~~ A verified petition alleging that the appointment of a ~~public conservator or~~ public guardian is required may be filed by: the commissioner; the local agency; a person with a developmental disability; or a parent, stepparent, spouse, or relative of a person with a developmental disability.

Sec. 19. Minnesota Statutes 2020, section 252A.06, subdivision 2, is amended to read:

Subd. 2. **Contents.** The petition shall set forth:

(1) the name and address of the petitioner~~,~~ and, in the case of a petition brought by a person other than the commissioner, whether the petitioner is a parent, spouse, or relative ~~of the proposed ward~~ of the proposed person subject to guardianship;

(2) whether the commissioner has accepted a nomination to act as ~~public conservator or~~ public guardian;

(3) the name, address, and date of birth of the proposed ~~ward~~ person subject to public guardianship;

(4) the names and addresses of the nearest relatives and spouse, if any, of the proposed ~~ward~~ person subject to public guardianship;

(5) the probable value and general character of the ~~proposed ward's~~ real and personal property of the proposed person subject to public guardianship and the probable amount of the ~~proposed ward's~~ debts of the proposed person subject to public guardianship; and

(6) the facts supporting the establishment of public ~~conservatorship or~~ guardianship, including that no family member or other qualified individual is willing to assume guardianship ~~or conservatorship~~ responsibilities under sections 524.5-101 to 524.5-502~~;~~ ~~and~~.

~~(7) if conservatorship is requested, the powers the petitioner believes are necessary to protect and supervise the proposed conservatee.~~

Sec. 20. Minnesota Statutes 2020, section 252A.07, subdivision 1, is amended to read:

Subdivision 1. **With petition.** When a petition is brought by the commissioner or local agency, a copy of the comprehensive evaluation shall be filed with the petition. If a petition is brought by a person other than the commissioner or local agency and a comprehensive evaluation has been prepared within a year of the filing of the petition, the local agency shall ~~forward~~ send a copy of the comprehensive evaluation to the court upon notice of the filing of the petition. If a comprehensive evaluation has not been prepared within a year of the filing of the petition, the local agency, upon notice of the filing of the petition, shall arrange for a comprehensive evaluation to be prepared and ~~forwarded~~ provided to the court within 90 days.

Sec. 21. Minnesota Statutes 2020, section 252A.07, subdivision 2, is amended to read:

Subd. 2. **Copies.** A copy of the comprehensive evaluation shall be made available by the court to the proposed ~~ward~~ person subject to public guardianship, the ~~proposed ward's~~ counsel of the proposed person subject to public guardianship, the county attorney, the attorney general, and the petitioner.

Sec. 22. Minnesota Statutes 2020, section 252A.07, subdivision 3, is amended to read:

Subd. 3. **Evaluation required; exception.** (a) No action for the appointment of a public guardian may proceed to hearing unless a comprehensive evaluation has been first filed with the court~~; provided, however, that an action may proceed and a guardian appointed~~.

(b) Paragraph (a) does not apply if the director of the local agency responsible for conducting the comprehensive evaluation has filed an affidavit that the proposed ~~ward~~ person subject to public guardianship refused to participate in the comprehensive evaluation and the court finds on the basis of clear and convincing evidence that the proposed ~~ward~~ person subject to public guardianship is developmentally disabled and in need of the supervision and protection of a guardian.

Sec. 23. Minnesota Statutes 2020, section 252A.081, subdivision 2, is amended to read:

Subd. 2. **Service of notice.** Service of notice on the ~~ward~~ person subject to public guardianship or proposed ~~ward~~ person subject to public guardianship must be made by a nonuniformed person or nonuniformed visitor. To the extent possible, the ~~process server or visitor~~ person or visitor serving the notice shall explain the document's meaning to the proposed ~~ward~~ person subject to public guardianship. In addition to the persons required to be served under sections 524.5-113, 524.5-205, and 524.5-304, the mailed notice of the hearing must be served on the commissioner, the local agency, and the county attorney.

Sec. 24. Minnesota Statutes 2020, section 252A.081, subdivision 3, is amended to read:

Subd. 3. **Attorney.** In place of the notice of attorney provisions in sections 524.5-205 and 524.5-304, the notice must state that the court will appoint an attorney for the proposed ~~ward~~ person subject to public guardianship unless an attorney is provided by other persons.

Sec. 25. Minnesota Statutes 2020, section 252A.081, subdivision 5, is amended to read:

Subd. 5. **Defective notice of service.** A defect in the service of notice or process, other than personal service upon the proposed ~~ward or conservatee~~ person subject to public guardianship or service upon the commissioner and local agency within the time allowed and the form prescribed in this section and sections 524.5-113, 524.5-205, and 524.5-304, does not invalidate any public guardianship ~~or conservatorship~~ proceedings.

Sec. 26. Minnesota Statutes 2020, section 252A.09, subdivision 1, is amended to read:

Subdivision 1. **Attorney appointment.** Upon the filing of the petition, the court shall appoint an attorney for the proposed ~~ward~~ person subject to public guardianship, unless such counsel is provided by others.

Sec. 27. Minnesota Statutes 2020, section 252A.09, subdivision 2, is amended to read:

Subd. 2. **Representation.** Counsel shall visit with and, to the extent possible, consult with the proposed ~~ward~~ person subject to public guardianship prior to the hearing and shall be given adequate time to prepare ~~therefor~~ for the hearing. Counsel shall be given the full right of subpoena and shall be supplied with a copy of all documents filed with or issued by the court.

Sec. 28. Minnesota Statutes 2020, section 252A.101, subdivision 2, is amended to read:

Subd. 2. **Waiver of presence.** The proposed ~~ward~~ person subject to public guardianship may waive the right to be present at the hearing only if the proposed ~~ward~~ person subject to public guardianship has met with counsel and specifically waived the right to appear.

Sec. 29. Minnesota Statutes 2020, section 252A.101, subdivision 3, is amended to read:

Subd. 3. **Medical care.** If, at the time of the hearing, the proposed ~~ward~~ person subject to public guardianship has been under medical care, the ~~ward~~ person subject to public guardianship has the same rights regarding limitation on the use of drugs, medication, or other treatment before the hearing that are available under section 252A.04, subdivision 2.

Sec. 30. Minnesota Statutes 2020, section 252A.101, subdivision 5, is amended to read:

Subd. 5. **Findings.** (a) In all cases the court shall make specific written findings of fact, conclusions of law, and direct entry of an appropriate judgment or order. The court shall order the appointment of the commissioner as guardian ~~or conservator~~ if it finds that:

(1) the proposed ~~ward or conservatee~~ person subject to public guardianship is a person with a developmental disability as defined in section 252A.02, subdivision 2;

(2) the proposed ~~ward or conservatee~~ person subject to public guardianship is incapable of exercising specific legal rights, which must be enumerated in ~~its~~ the court's findings;

(3) the proposed ~~ward or conservatee~~ person subject to public guardianship is in need of the supervision and protection of a public guardian ~~or conservator~~; and

(4) no appropriate alternatives to public guardianship ~~or public conservatorship~~ exist that are less restrictive of the person's civil rights and liberties, such as appointing a private guardian, ~~or conservator~~ supported decision maker, or health care agent; or arranging residential or community services under sections 524.5-101 to 524.5-502.

(b) The court shall grant the specific powers that are necessary for the commissioner to act as public guardian ~~or conservator~~ on behalf of the ~~ward or conservatee~~ person subject to public guardianship.

Sec. 31. Minnesota Statutes 2020, section 252A.101, subdivision 6, is amended to read:

Subd. 6. **Notice of order; appeal.** A copy of the order shall be served by mail upon the ~~ward or conservatee~~ person subject to public guardianship and the ~~ward's~~ counsel of the person subject to public guardianship. The order must be accompanied by a notice that advises the ~~ward or conservatee~~ person subject to public guardianship of the right to appeal the guardianship ~~or conservatorship~~ appointment within 30 days.

Sec. 32. Minnesota Statutes 2020, section 252A.101, subdivision 7, is amended to read:

Subd. 7. **Letters of guardianship.** (a) Letters of guardianship ~~or conservatorship~~ must be issued by the court and contain:

(1) the name, address, and telephone number of the ~~ward or conservatee~~ person subject to public guardianship; and

(2) the powers to be exercised on behalf of the ~~ward or conservatee~~ person subject to public guardianship.

(b) The letters under paragraph (a) must be served by mail upon the ~~ward or conservatee~~ person subject to public guardianship, the ~~ward's~~ counsel of the person subject to public guardianship, the commissioner, and the local agency.

Sec. 33. Minnesota Statutes 2020, section 252A.101, subdivision 8, is amended to read:

Subd. 8. **Dismissal.** If upon the completion of the hearing and consideration of the record, the court finds that the proposed ~~ward~~ person subject to public guardianship is not developmentally disabled or is developmentally disabled but not in need of the supervision and protection of a ~~conservator or~~ public guardian, ~~it~~ the court shall dismiss the application and shall notify the proposed ~~ward~~ person subject to public guardianship, the ~~ward's~~ counsel of the person subject to public guardianship, and the petitioner of the court's findings.

Sec. 34. Minnesota Statutes 2020, section 252A.111, subdivision 2, is amended to read:

Subd. 2. **Additional powers.** In addition to the powers contained in sections 524.5-207 and 524.5-313, the powers of a public guardian that the court may grant include:

(1) the power to permit or withhold permission for the ~~ward~~ person subject to public guardianship to marry;

(2) the power to begin legal action or defend against legal action in the name of the ~~ward~~ person subject to public guardianship; and

(3) the power to consent to the adoption of the ~~ward~~ person subject to public guardianship as provided in section 259.24.

Sec. 35. Minnesota Statutes 2020, section 252A.111, subdivision 4, is amended to read:

Subd. 4. **Appointment of conservator.** If the ~~ward~~ person subject to public guardianship has a personal estate beyond that which is necessary for the ~~ward's~~ personal and immediate needs of the person subject to public guardianship, the commissioner shall determine whether a conservator should be appointed. The commissioner shall consult with the parents, spouse, or nearest relative of the ~~ward~~ person subject to public guardianship. The commissioner may petition the court for the appointment of a private conservator of the ~~ward~~ person subject to public guardianship. The commissioner cannot act as conservator for public ~~wards~~ persons subject to public guardianship or public protected persons.

Sec. 36. Minnesota Statutes 2020, section 252A.111, subdivision 6, is amended to read:

Subd. 6. **Special duties.** In exercising powers and duties under this chapter, the commissioner shall:

(1) maintain close contact with the ~~ward~~ person subject to public guardianship, visiting at least twice a year;

(2) protect and exercise the legal rights of the ~~ward~~ person subject to public guardianship;

(3) take actions and make decisions on behalf of the ~~ward~~ person subject to public guardianship that encourage and allow the maximum level of independent functioning in a manner least restrictive of the ~~ward's~~ personal freedom of the person subject to public guardianship consistent with the need for supervision and protection; and

(4) permit and encourage maximum self-reliance on the part of the ~~ward~~ person subject to public guardianship and permit and encourage input by the nearest relative of the ~~ward~~ person subject to public guardianship in planning and decision making on behalf of the ~~ward~~ person subject to public guardianship.

Sec. 37. Minnesota Statutes 2020, section 252A.12, is amended to read:

252A.12 APPOINTMENT OF ~~CONSERVATOR~~ PUBLIC GUARDIAN NOT A FINDING OF INCOMPETENCY.

An appointment of the commissioner as ~~conservator~~ public guardian shall not constitute a judicial finding that the person with a developmental disability is legally incompetent except for the restrictions ~~which~~ that the ~~conservatorship~~ public guardianship places on the ~~conservatee~~ person subject to public guardianship. The appointment of a ~~conservator~~ public guardian shall not deprive the ~~conservatee~~ person subject to public guardianship of the right to vote.

Sec. 38. Minnesota Statutes 2020, section 252A.16, is amended to read:

252A.16 ANNUAL REVIEW.

Subdivision 1. **Review required.** The commissioner shall require an annual review of the physical, mental, and social adjustment and progress of every ~~ward and conservatee~~ person subject to public guardianship. A copy of this review shall be kept on file at the Department of Human Services and may be inspected by the ~~ward or conservatee~~ person subject to public guardianship, the ~~ward's or conservatee's~~ parents, spouse, or relatives of the person subject to public guardianship, and other persons who receive the permission of the commissioner. The review shall contain information required under Minnesota Rules, part 9525.3065, subpart 1.

Subd. 2. **Assessment of need for continued guardianship.** The commissioner shall annually review the legal status of each ~~ward~~ person subject to public guardianship in light of the progress indicated in the annual review. If the commissioner determines the ~~ward~~ person subject to public guardianship is no longer in need of public guardianship ~~or conservatorship~~ or is capable of functioning under a less restrictive ~~conservatorship~~ guardianship, the commissioner or local agency shall petition the court pursuant to section 252A.19 to restore the ~~ward~~ person subject to public guardianship to capacity or for a modification of the court's previous order.

Sec. 39. Minnesota Statutes 2020, section 252A.17, is amended to read:

252A.17 EFFECT OF SUCCESSION IN OFFICE.

The appointment by the court of the commissioner ~~of human services~~ as public ~~conservator or~~ guardian shall be by the title of the commissioner's office. The authority of the commissioner as public ~~conservator or~~ guardian shall cease upon the termination of the commissioner's term of office and shall vest in a successor or successors in office without further court proceedings.

Sec. 40. Minnesota Statutes 2020, section 252A.19, subdivision 2, is amended to read:

Subd. 2. **Petition.** The commissioner, ~~ward~~ person subject to public guardianship, or any interested person may petition the appointing court or the court to which venue has been transferred ~~for an order to~~:

(1) for an order to remove the guardianship ~~or to~~;

(2) for an order to limit or expand the powers of the guardianship ~~or to~~;

(3) for an order to appoint a guardian ~~or conservator~~ under sections 524.5-101 to 524.5-502 ~~or to~~;

(4) for an order to restore the ~~ward~~ person subject to public guardianship or protected person to full legal capacity ~~or to~~;

(5) to review de novo any decision made by the public guardian ~~or public conservator~~ for or on behalf of a ~~ward~~ person subject to public guardianship or protected person; or

(6) for any other order as the court may deem just and equitable.

Sec. 41. Minnesota Statutes 2020, section 252A.19, subdivision 4, is amended to read:

Subd. 4. **Comprehensive evaluation.** The commissioner shall, at the court's request, arrange for the preparation of a comprehensive evaluation of the ~~ward~~ person subject to public guardianship or protected person.

Sec. 42. Minnesota Statutes 2020, section 252A.19, subdivision 5, is amended to read:

Subd. 5. **Court order.** Upon proof of the allegations of the petition the court shall enter an order removing the guardianship or limiting or expanding the powers of the guardianship or restoring the ~~ward~~ person subject to public guardianship or protected person to full legal capacity or may enter such other order as the court may deem just and equitable.

Sec. 43. Minnesota Statutes 2020, section 252A.19, subdivision 7, is amended to read:

Subd. 7. **Attorney general's role; commissioner's role.** The attorney general may appear and represent the commissioner in such proceedings. The commissioner shall support or oppose the petition if the commissioner deems such action necessary for the protection and supervision of the ~~ward~~ person subject to public guardianship or protected person.

Sec. 44. Minnesota Statutes 2020, section 252A.19, subdivision 8, is amended to read:

Subd. 8. ~~**Court appointed**~~ **Court-appointed counsel.** In all such proceedings, the protected person or ~~ward~~ person subject to public guardianship shall be afforded an opportunity to be represented by counsel, and if neither the protected person or ~~ward~~ person subject to public guardianship nor others provide counsel the court shall appoint counsel to represent the protected person or ~~ward~~ person subject to public guardianship.

Sec. 45. Minnesota Statutes 2020, section 252A.20, is amended to read:

252A.20 COSTS OF HEARINGS.

Subdivision 1. **Witness and attorney fees.** In each proceeding under sections 252A.01 to 252A.21, the court shall allow and order paid to each witness subpoenaed the fees and mileage prescribed by law; to each physician, advanced practice registered nurse, psychologist, or social worker who assists in the preparation of the comprehensive evaluation and who is not ~~in the employ of~~ employed by the local agency or the state Department of Human Services, a reasonable sum for services and for travel; and to the ~~ward's~~ counsel of the person subject to public guardianship, when appointed by the court, a reasonable sum for travel and for each day or portion of a day actually employed in court or actually consumed in preparing for the hearing. Upon order the county auditor shall issue a warrant on the county treasurer for payment of the amount allowed.

Subd. 2. **Expenses.** When the settlement of the ~~ward~~ person subject to public guardianship is found to be in another county, the court shall transmit to the county auditor a statement of the expenses incurred pursuant to subdivision 1. The auditor shall transmit the statement to the auditor of the county of the ~~ward's~~ settlement of the person subject to public guardianship and this claim shall be paid as other claims against that county. If the auditor to whom this claim is transmitted denies the claim, the auditor shall transmit it, together with the objections thereto, to the commissioner, who shall determine the question of settlement and certify findings to each auditor. If the claim is not paid within 30 days after such certification, an action may be maintained thereon in the district court of the claimant county.

Subd. 3. **Change of venue; cost of proceedings.** Whenever venue of a proceeding has been transferred under sections 252A.01 to 252A.21, the costs of such proceedings shall be reimbursed to the county of the ~~ward's~~ settlement of the person subject to public guardianship by the state.

Sec. 46. Minnesota Statutes 2020, section 252A.21, subdivision 2, is amended to read:

Subd. 2. **Rules.** The commissioner shall adopt rules to implement this chapter. The rules must include standards for performance of guardianship ~~or conservatorship~~ duties including~~,~~ but not limited to: twice a year visits with the ~~ward~~ person subject to public guardianship; a requirement that the duties of guardianship ~~or conservatorship~~ and case management not be performed by the same person; specific standards for action on "do not resuscitate" orders as recommended by a physician, an advanced practice registered nurse, or a physician assistant; sterilization requests; and the use of psychotropic medication and aversive procedures.

Sec. 47. Minnesota Statutes 2020, section 252A.21, subdivision 4, is amended to read:

Subd. 4. **Private guardianships ~~and conservatorships.~~** Nothing in sections 252A.01 to 252A.21 shall impair the right of individuals to establish private guardianships ~~or conservatorships~~ in accordance with applicable law.

Sec. 48. Minnesota Statutes 2020, section 254B.03, subdivision 2, is amended to read:

Subd. 2. **Chemical dependency fund payment.** (a) Payment from the chemical dependency fund is limited to payments for services identified in section 254B.05, other than detoxification licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, ~~that, if located outside of federally recognized tribal lands, would be required to be licensed by the commissioner as a chemical dependency treatment or rehabilitation program under sections 245A.01 to 245A.16,~~ and ~~services other than~~ detoxification provided in another state that would be required to be licensed as a chemical dependency program if the program were in the state. Out of state vendors must also provide the commissioner with assurances that the program complies substantially with state licensing requirements and possesses all licenses and certifications required by the host state to provide chemical dependency treatment. Vendors receiving payments from the chemical dependency fund must not require

co-payment from a recipient of benefits for services provided under this subdivision. The vendor is prohibited from using the client's public benefits to offset the cost of services paid under this section. The vendor shall not require the client to use public benefits for room or board costs. This includes but is not limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP benefits. Retention of SNAP benefits is a right of a client receiving services through the consolidated chemical dependency treatment fund or through state contracted managed care entities. Payment from the chemical dependency fund shall be made for necessary room and board costs provided by vendors meeting the criteria under section 254B.05, subdivision 1a, or in a community hospital licensed by the commissioner of health according to sections 144.50 to 144.56 to a client who is:

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

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

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

(c) The commissioner shall coordinate chemical dependency services and determine whether there is a need for any proposed expansion of chemical dependency treatment services. The commissioner shall deny vendor certification to any provider that has not received prior approval from the commissioner for the creation of new programs or the expansion of existing program capacity. The commissioner shall consider the provider's capacity to obtain clients from outside the state based on plans, agreements, and previous utilization history, when determining the need for new treatment services.

Sec. 49. Minnesota Statutes 2020, section 256B.051, subdivision 1, is amended to read:

Subdivision 1. **Purpose.** Housing ~~support~~ stabilization services are established to provide housing ~~support~~ stabilization services to an individual with a disability that limits the individual's ability to obtain or maintain stable housing. The services support an individual's transition to housing in the community and increase long-term stability in housing, to avoid future periods of being at risk of homelessness or institutionalization.

Sec. 50. Minnesota Statutes 2020, section 256B.051, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** An individual with a disability is eligible for housing ~~support~~ stabilization services if the individual:

(1) is 18 years of age or older;

(2) is enrolled in medical assistance;

(3) has an assessment of functional need that determines a need for services due to limitations caused by the individual's disability;

(4) resides in or plans to transition to a community-based setting as defined in Code of Federal Regulations, title 42, section 441.301 (c); and

(5) has housing instability evidenced by:

(i) being homeless or at-risk of homelessness;

(ii) being in the process of transitioning from, or having transitioned in the past six months from, an institution or licensed or registered setting;

(iii) being eligible for waiver services under chapter 256S or section 256B.092 or 256B.49; or

(iv) having been identified by a long-term care consultation under section 256B.0911 as at risk of institutionalization.

Sec. 51. Minnesota Statutes 2020, section 256B.051, subdivision 5, is amended to read:

Subd. 5. **Housing ~~support~~ stabilization services.** (a) Housing ~~support~~ stabilization services include housing transition services and housing and tenancy sustaining services.

(b) Housing transition services are defined as:

(1) tenant screening and housing assessment;

(2) assistance with the housing search and application process;

(3) identifying resources to cover onetime moving expenses;

(4) ensuring a new living arrangement is safe and ready for move-in;

(5) assisting in arranging for and supporting details of a move; and

(6) developing a housing support crisis plan.

(c) Housing and tenancy sustaining services include:

(1) prevention and early identification of behaviors that may jeopardize continued stable housing;

(2) education and training on roles, rights, and responsibilities of the tenant and the property manager;

(3) coaching to develop and maintain key relationships with property managers and neighbors;

(4) advocacy and referral to community resources to prevent eviction when housing is at risk;

(5) assistance with housing recertification process;

(6) coordination with the tenant to regularly review, update, and modify the housing support and crisis plan; and

(7) continuing training on being a good tenant, lease compliance, and household management.

(d) A housing ~~support~~ stabilization service may include person-centered planning for people who are not eligible to receive person-centered planning through any other service, if the person-centered planning is provided by a consultation service provider that is under contract with the department and enrolled as a Minnesota health care program.

Sec. 52. Minnesota Statutes 2020, section 256B.051, subdivision 6, is amended to read:

Subd. 6. **Provider qualifications and duties.** A provider eligible for reimbursement under this section shall:

(1) enroll as a medical assistance Minnesota health care program provider and meet all applicable provider standards and requirements;

(2) demonstrate compliance with federal and state laws and policies for housing ~~support~~ stabilization services as determined by the commissioner;

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

(4) directly provide housing ~~support~~ stabilization services and not use a subcontractor or reporting agent~~.~~; and

(5) complete annual vulnerable adult training.

Sec. 53. Minnesota Statutes 2020, section 256B.051, subdivision 7, is amended to read:

Subd. 7. **Housing support supplemental service rates.** Supplemental service rates for individuals in settings according to sections 144D.025, 256I.04, subdivision 3, paragraph (a), clause (3), and 256I.05, subdivision 1g, shall be reduced by one-half over a two-year period. This reduction only applies to supplemental service rates for individuals eligible for housing ~~support~~ stabilization services under this section.

House Language H2128-4

Section 1. Minnesota Statutes 2020, section 256B.0947, subdivision 6, is amended to read:

Subd. 6. **Service standards.** The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services.

(a) The treatment team must use team treatment, not an individual treatment model.

(b) Services must be available at times that meet client needs.

(c) Services must be age-appropriate and meet the specific needs of the client.

(d) The initial functional assessment must be completed within ten days of intake and updated at least every six months or prior to discharge from the service, whichever comes first.

(e) The treatment team must complete an individual treatment plan for each client and the individual treatment plan must:

(1) be based on the information in the client's diagnostic assessment and baselines;

(2) identify goals and objectives of treatment, a treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports;

Senate Language UEH2128-1

Sec. 54. Minnesota Statutes 2020, section 256B.051, is amended by adding a subdivision to read:

Subd. 8. **Documentation requirements.** (a) Documentation may be collected and maintained electronically or in paper form by providers and must be produced upon request by the commissioner.

(b) Documentation of a delivered service must be in English and must be legible according to the standard of a reasonable person.

(c) If the service is reimbursed at an hourly or specified minute-based rate, each documentation of the provision of a service, unless otherwise specified, must include:

(1) the date the documentation occurred;

(2) the day, month, and year the service was provided;

(3) the start and stop times with a.m. and p.m. designations, except for person-centered planning services described under subdivision 5, paragraph (d);

(4) the service name or description of the service provided; and

(5) the name, signature, and title, if any, of the provider of service. If the service is provided by multiple staff members, the provider may designate a staff member responsible for verifying services and completing the documentation required by this paragraph.

Sec. 55. Minnesota Statutes 2020, section 256B.0947, subdivision 6, is amended to read:

Subd. 6. **Service standards.** The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services.

(a) The treatment team must use team treatment, not an individual treatment model.

(b) Services must be available at times that meet client needs.

(c) Services must be age-appropriate and meet the specific needs of the client.

(d) The initial functional assessment must be completed within ten days of intake and updated at least every six months or prior to discharge from the service, whichever comes first.

(e) The treatment team must complete an individual treatment plan for each client and the individual treatment plan must:

(1) be based on the information in the client's diagnostic assessment and baselines;

(2) identify goals and objectives of treatment, a treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports;

(3) be developed after completion of the client's diagnostic assessment by a mental health professional or clinical trainee and before the provision of children's therapeutic services and supports;

(4) be developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessments, and treatment planning;

(5) be reviewed at least once every six months and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment;

(6) be signed by the clinical supervisor and by the client or by the client's parent or other person authorized by statute to consent to mental health services for the client. A client's parent may approve the client's individual treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature;

(7) be completed in consultation with the client's current therapist and key providers and provide for ongoing consultation with the client's current therapist to ensure therapeutic continuity and to facilitate the client's return to the community. For clients under the age of 18, the treatment team must consult with parents and guardians in developing the treatment plan;

(8) if a need for substance use disorder treatment is indicated by validated assessment:

(i) identify goals, objectives, and strategies of substance use disorder treatment; develop a schedule for accomplishing treatment goals and objectives; and identify the individuals responsible for providing treatment services and supports;

(ii) be reviewed at least once every 90 days and revised, if necessary;

(9) be signed by the clinical supervisor and by the client and, if the client is a minor, by the client's parent or other person authorized by statute to consent to mental health treatment and substance use disorder treatment for the client; and

(10) provide for the client's transition out of intensive nonresidential rehabilitative mental health services by defining the team's actions to assist the client and subsequent providers in the transition to less intensive or "stepped down" services.

(f) The treatment team shall actively and assertively engage the client's family members and significant others by establishing communication and collaboration with the family and significant others and educating the family and significant others about the client's mental illness, symptom management, and the family's role in treatment, unless the team knows or has reason to suspect that the client has suffered or faces a threat of suffering any physical or mental injury, abuse, or neglect from a family member or significant other.

(g) For a client age 18 or older, the treatment team may disclose to a family member, other relative, or a close personal friend of the client, or other person identified by the client,

(3) be developed after completion of the client's diagnostic assessment by a mental health professional or clinical trainee and before the provision of children's therapeutic services and supports;

(4) be developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessments, and treatment planning;

(5) be reviewed at least once every six months and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment;

(6) be signed by the clinical supervisor and by the client or by the client's parent or other person authorized by statute to consent to mental health services for the client. A client's parent may approve the client's individual treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature;

(7) be completed in consultation with the client's current therapist and key providers and provide for ongoing consultation with the client's current therapist to ensure therapeutic continuity and to facilitate the client's return to the community. For clients under the age of 18, the treatment team must consult with parents and guardians in developing the treatment plan;

(8) if a need for substance use disorder treatment is indicated by validated assessment:

(i) identify goals, objectives, and strategies of substance use disorder treatment; develop a schedule for accomplishing treatment goals and objectives; and identify the individuals responsible for providing treatment services and supports;

(ii) be reviewed at least once every 90 days and revised, if necessary;

(9) be signed by the clinical supervisor and by the client and, if the client is a minor, by the client's parent or other person authorized by statute to consent to mental health treatment and substance use disorder treatment for the client; and

(10) provide for the client's transition out of intensive nonresidential rehabilitative mental health services by defining the team's actions to assist the client and subsequent providers in the transition to less intensive or "stepped down" services.

(f) The treatment team shall actively and assertively engage the client's family members and significant others by establishing communication and collaboration with the family and significant others and educating the family and significant others about the client's mental illness, symptom management, and the family's role in treatment, unless the team knows or has reason to suspect that the client has suffered or faces a threat of suffering any physical or mental injury, abuse, or neglect from a family member or significant other.

(g) For a client age 18 or older, the treatment team may disclose to a family member, other relative, or a close personal friend of the client, or other person identified by the client,

the protected health information directly relevant to such person's involvement with the client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the client is present, the treatment team shall obtain the client's agreement, provide the client with an opportunity to object, or reasonably infer from the circumstances, based on the exercise of professional judgment, that the client does not object. If the client is not present or is unable, by incapacity or emergency circumstances, to agree or object, the treatment team may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the client and, if so, disclose only the protected health information that is directly relevant to the family member's, relative's, friend's, or client-identified person's involvement with the client's health care. The client may orally agree or object to the disclosure and may prohibit or restrict disclosure to specific individuals.

(h) The treatment team shall provide interventions to promote positive interpersonal relationships.

Sec. 2. Minnesota Statutes 2020, section 256B.69, subdivision 5a, is amended to read:

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B and 256L is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B

the protected health information directly relevant to such person's involvement with the client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the client is present, the treatment team shall obtain the client's agreement, provide the client with an opportunity to object, or reasonably infer from the circumstances, based on the exercise of professional judgment, that the client does not object. If the client is not present or is unable, by incapacity or emergency circumstances, to agree or object, the treatment team may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the client and, if so, disclose only the protected health information that is directly relevant to the family member's, relative's, friend's, or client-identified person's involvement with the client's health care. The client may orally agree or object to the disclosure and may prohibit or restrict disclosure to specific individuals.

(h) The treatment team shall provide interventions to promote positive interpersonal relationships.

Sec. 56. Minnesota Statutes 2020, section 256B.4912, subdivision 13, is amended to read:

Subd. 13. **Waiver transportation documentation and billing requirements.** (a) A waiver transportation service must be a waiver transportation service that: (1) is not covered by medical transportation under the Medicaid state plan; and (2) is not included as a component of another waiver service.

(b) In addition to the documentation requirements in subdivision 12, a waiver transportation service provider must maintain:

(1) odometer and other records pursuant to section 256B.0625, subdivision 17b, paragraph (b), clause (3), sufficient to distinguish an individual trip with a specific vehicle and driver for a waiver transportation service that is billed directly by the mile. A common carrier as defined by Minnesota Rules, part 9505.0315, subpart 1, item B, or a publicly operated transit system provider are exempt from this clause; and

(2) documentation demonstrating that a vehicle and a driver meet the ~~standards determined by the Department of Human Services on vehicle and driver qualifications in section 256B.0625, subdivision 17, paragraph (c)~~ transportation waiver service provider standards and qualifications according to the federally approved waiver plan.

Sec. 57. Minnesota Statutes 2020, section 256B.69, subdivision 5a, is amended to read:

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B and 256L is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B

and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) The commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

(d) The commissioner shall require that managed care plans use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659 and community first services and supports under section 256B.85.

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous measurement year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the

and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) The commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

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(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous measurement year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the

managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(f) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous calendar year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospital admission rate compared to the hospital admission rates in calendar year 2011, as determined by the commissioner. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(f) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous calendar year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospital admission rate compared to the hospital admission rates in calendar year 2011, as determined by the commissioner. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(g) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

(h) Effective for services rendered on or after January 1, 2013, through December 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(i) Effective for services rendered on or after January 1, 2014, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(j) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

(k) Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7.

(g) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

(h) Effective for services rendered on or after January 1, 2013, through December 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(i) Effective for services rendered on or after January 1, 2014, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(j) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

(k) Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7.

(l) The return of the withhold under paragraphs (h) and (i) is not subject to the requirements of paragraph (c).

(m) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public health care programs. Subcontractor agreements determined to be material, as defined by the commissioner after taking into account state contracting and relevant statutory requirements, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to state public health care programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

Sec. 3. Minnesota Statutes 2020, section 256B.85, subdivision 1, is amended to read:

Subdivision 1. **Basis and scope.** (a) Upon federal approval, the commissioner shall establish a state plan option for the provision of home and community-based personal assistance service and supports called "community first services and supports (CFSS)."

(b) CFSS is a participant-controlled method of selecting and providing services and supports that allows the participant maximum control of the services and supports. Participants may choose the degree to which they direct and manage their supports by choosing to have a significant and meaningful role in the management of services and supports including by directly employing support workers with the necessary supports to perform that function.

(c) CFSS is available statewide to eligible people to assist with accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related procedures and tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task; and to assist with acquiring, maintaining, and enhancing the skills necessary to accomplish ADLs, IADLs, and health-related procedures and tasks. CFSS allows payment for the participant for certain supports and goods such as environmental modifications and technology that are intended to replace or decrease the need for human assistance.

(d) Upon federal approval, CFSS will replace the personal care assistance program under sections 256.476, 256B.0625, subdivisions 19a and 19c, and 256B.0659.

(e) For the purposes of this section, notwithstanding the provisions of section 144A.43, subdivision 3, supports purchased under CFSS are not considered home care services.

Sec. 4. Minnesota Statutes 2020, 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.

(l) The return of the withhold under paragraphs (h) and (i) is not subject to the requirements of paragraph (c).

(m) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public health care programs. Subcontractor agreements determined to be material, as defined by the commissioner after taking into account state contracting and relevant statutory requirements, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to state public health care programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

Sec. 58. Minnesota Statutes 2020, section 256B.85, subdivision 1, is amended to read:

Subdivision 1. **Basis and scope.** (a) Upon federal approval, the commissioner shall establish a state plan option for the provision of home and community-based personal assistance service and supports called "community first services and supports (CFSS)."

(b) CFSS is a participant-controlled method of selecting and providing services and supports that allows the participant maximum control of the services and supports. Participants may choose the degree to which they direct and manage their supports by choosing to have a significant and meaningful role in the management of services and supports including by directly employing support workers with the necessary supports to perform that function.

(c) CFSS is available statewide to eligible people to assist with accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related procedures and tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task; and to assist with acquiring, maintaining, and enhancing the skills necessary to accomplish ADLs, IADLs, and health-related procedures and tasks. CFSS allows payment for the participant for certain supports and goods such as environmental modifications and technology that are intended to replace or decrease the need for human assistance.

(d) Upon federal approval, CFSS will replace the personal care assistance program under sections 256.476, 256B.0625, subdivisions 19a and 19c, and 256B.0659.

(e) For the purposes of this section, notwithstanding the provisions of section 144A.43, subdivision 3, supports purchased under CFSS are not considered home care services.

Sec. 59. Minnesota Statutes 2020, 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, applying, and changing clothing and applying 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. Grooming includes nail care, 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 applying orthotics required for eating, transfers, or feeding;

(5) transfers, including assistance with transferring the participant 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 participant;

(7) positioning, including assistance with positioning or turning a participant 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, advanced practice registered nurse, or physician's assistant and is specified in a community support plan, including:

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

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

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

(1) dressing, including assistance with choosing, applying, and changing clothing and applying 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. Grooming includes nail care, 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 applying orthotics required for eating, transfers, or feeding;

(5) transfers, including assistance with transferring the participant 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 participant;

(7) positioning, including assistance with positioning or turning a participant 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, advanced practice registered nurse, or physician's assistant and is specified in a community 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, advanced practice registered nurse, or physician's assistant and requiring specialized assistance from another on a daily basis; and

(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;

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(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

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(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, advanced practice registered nurse, or physician's assistant 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.092, subdivision 1b, and 256S.10.

(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~~ must 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 chapter 256S and sections 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;

(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.092, subdivision 1b, and 256S.10.

(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.

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(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~~ must 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 chapter 256S and sections 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~~ must 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~~

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 toward ~~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~~ must 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~~ a written agreement to receive services at the same time ~~and~~, in the same setting ~~by~~, and through the same ~~employer~~ agency-provider or FMS provider.

(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.

~~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~~ a written agreement to receive services at the same time ~~and~~, in the same setting ~~by~~, and through the same ~~employer~~ agency-provider or FMS provider.

(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. 5. Minnesota Statutes 2020, section 256B.85, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** (a) CFSS is available to a person who ~~meets one of the following~~:

~~(1) is an enrollee of medical assistance as determined under section 256B.055, 256B.056, or 256B.057, subdivisions 5 and 9;~~

(1) is determined eligible for medical assistance under this chapter, excluding those under section 256B.057, subdivisions 3, 3a, 3b, and 4;

(2) is a participant in the alternative care program under section 256B.0913;

(3) is a waiver participant as defined under chapter 256S or section 256B.092, 256B.093, or 256B.49; or

(4) has medical services identified in a person's individualized education program and is eligible for services as determined in section 256B.0625, subdivision 26.

(b) In addition to meeting the eligibility criteria in paragraph (a), a person must also meet all of the following:

(1) require assistance and be determined dependent in one activity of daily living or Level I behavior based on assessment under section 256B.0911; and

(2) is not a participant under a family support grant under section 252.32.

(c) A pregnant woman eligible for medical assistance under section 256B.055, subdivision 6, is eligible for CFSS without federal financial participation if the woman: (1) is eligible for CFSS under paragraphs (a) and (b); and (2) does not meet institutional level of care, as determined under section 256B.0911.

Sec. 6. Minnesota Statutes 2020, 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. 7. Minnesota Statutes 2020, 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.

Sec. 60. Minnesota Statutes 2020, section 256B.85, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** (a) CFSS is available to a person who ~~meets one of the following~~:

~~(1) is an enrollee of medical assistance as determined under section 256B.055, 256B.056, or 256B.057, subdivisions 5 and 9;~~

(1) is determined eligible for medical assistance under this chapter, excluding those under section 256B.057, subdivisions 3, 3a, 3b, and 4;

(2) is a participant in the alternative care program under section 256B.0913;

(3) is a waiver participant as defined under chapter 256S or section 256B.092, 256B.093, or 256B.49; or

(4) has medical services identified in a person's individualized education program and is eligible for services as determined in section 256B.0625, subdivision 26.

(b) In addition to meeting the eligibility criteria in paragraph (a), a person must also meet all of the following:

(1) require assistance and be determined dependent in one activity of daily living or Level I behavior based on assessment under section 256B.0911; and

(2) is not a participant under a family support grant under section 252.32.

(c) A pregnant woman eligible for medical assistance under section 256B.055, subdivision 6, is eligible for CFSS without federal financial participation if the woman: (1) is eligible for CFSS under paragraphs (a) and (b); and (2) does not meet institutional level of care, as determined under section 256B.0911.

Sec. 61. Minnesota Statutes 2020, 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. 62. Minnesota Statutes 2020, 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 the participant's representative and chosen CFSS providers within ~~40 calendar~~ ten business days and must include the participant's right to appeal the assessment under section 256.045, subdivision 3.

(c) The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model. The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model without using the assessment process described in this subdivision. 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. ~~Participants approved for a temporary authorization shall access the consultation service~~ For CFSS services needed beyond the 45-day temporary authorization, the lead agency must conduct an assessment as described in this subdivision and participants must use consultation services to complete their orientation and selection of a service model.

Sec. 8. Minnesota Statutes 2020, 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.092, subdivision 1b, and 256S.10. 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;

(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 the participant's representative and chosen CFSS providers within ~~40 calendar~~ ten business days and must include the participant's right to appeal the assessment under section 256.045, subdivision 3.

(c) The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model. The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model without using the assessment process described in this subdivision. 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. ~~Participants approved for a temporary authorization shall access the consultation service~~ For CFSS services needed beyond the 45-day temporary authorization, the lead agency must conduct an assessment as described in this subdivision and participants must use consultation services to complete their orientation and selection of a service model.

Sec. 63. Minnesota Statutes 2020, 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.092, subdivision 1b, and 256S.10. 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~~/~~ or 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. 9. Minnesota Statutes 2020, section 256B.85, subdivision 7, is amended to read:

Subd. 7. **Community first services and supports; covered services.** Services and supports covered under CFSS include:

(1) assistance to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related procedures and tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task;

(2) assistance to acquire, maintain, or enhance the skills necessary for the participant to accomplish activities of daily living, instrumental activities of daily living, or health-related tasks;

(3) expenditures for items, services, supports, environmental modifications, or goods, including assistive technology. These expenditures must:

(i) relate to a need identified in a participant's CFSS service delivery plan; and

(ii) increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance for the participant's assessed needs;

(4) observation and redirection for behavior or symptoms where there is a need for assistance;

(5) back-up systems or mechanisms, such as the use of pagers or other electronic devices, to ensure continuity of the participant's services and supports;

(6) services provided by a consultation services provider as defined under subdivision 17, that is under contract with the department and enrolled as a Minnesota health care program provider;

(7) services provided by an FMS provider as defined under subdivision 13a, that is an enrolled provider with the department;

(8) CFSS services provided by a support worker who is a parent, stepparent, or legal guardian of a participant under age 18, or who is the participant's spouse. These support workers shall not:

(i) provide any medical assistance home and community-based services in excess of 40 hours per seven-day period regardless of the number of parents providing services, combination of parents and spouses providing services, or number of children who receive medical assistance services; and

services. A case manager or care coordinator must approve the plan for a waiver or alternative care program participant.

Sec. 64. Minnesota Statutes 2020, section 256B.85, subdivision 7, is amended to read:

Subd. 7. **Community first services and supports; covered services.** Services and supports covered under CFSS include:

(1) assistance to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related procedures and tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task;

(2) assistance to acquire, maintain, or enhance the skills necessary for the participant to accomplish activities of daily living, instrumental activities of daily living, or health-related tasks;

(3) expenditures for items, services, supports, environmental modifications, or goods, including assistive technology. These expenditures must:

(i) relate to a need identified in a participant's CFSS service delivery plan; and

(ii) increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance for the participant's assessed needs;

(4) observation and redirection for behavior or symptoms where there is a need for assistance;

(5) back-up systems or mechanisms, such as the use of pagers or other electronic devices, to ensure continuity of the participant's services and supports;

(6) services provided by a consultation services provider as defined under subdivision 17, that is under contract with the department and enrolled as a Minnesota health care program provider;

(7) services provided by an FMS provider as defined under subdivision 13a, that is an enrolled provider with the department;

(8) CFSS services provided by a support worker who is a parent, stepparent, or legal guardian of a participant under age 18, or who is the participant's spouse. These support workers shall not:

(i) provide any medical assistance home and community-based services in excess of 40 hours per seven-day period regardless of the number of parents providing services, combination of parents and spouses providing services, or number of children who receive medical assistance services; and

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(ii) have a wage that exceeds the current rate for a CFSS support worker including the wage, benefits, and payroll taxes; and

(9) worker training and development services as described in subdivision 18a.

Sec. 10. Minnesota Statutes 2020, 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;

Senate Language UEH2128-1

(ii) have a wage that exceeds the current rate for a CFSS support worker including the wage, benefits, and payroll taxes; and

(9) worker training and development services as described in subdivision 18a.

Sec. 65. Minnesota Statutes 2020, 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~~ for each behavior under this clause that requires assistance at least four times per week ~~for one or more of the following behaviors~~:

(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. 11. Minnesota Statutes 2020, section 256B.85, is amended by adding a subdivision to read:

Subd. 8a. **Authorization; exceptions.** All CFSS services must be authorized by the commissioner or the commissioner's designee as described in subdivision 8 except when:

(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~~ for each behavior under this clause that requires assistance at least four times per week ~~for one or more of the following behaviors~~:

(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. 66. Minnesota Statutes 2020, section 256B.85, is amended by adding a subdivision to read:

Subd. 8a. **Authorization; exceptions.** All CFSS services must be authorized by the commissioner or the commissioner's designee as described in subdivision 8 except when:

(1) the lead agency temporarily authorizes services in the agency-provider model as described in subdivision 5, paragraph (c);

(2) CFSS services in the agency-provider model were required to treat an emergency medical condition that if not immediately treated could cause a participant serious physical or mental disability, continuation of severe pain, or death. The CFSS agency provider must request retroactive authorization from the lead agency no later than five working days after providing the initial emergency service. The CFSS agency provider must be able to substantiate the emergency through documentation such as reports, notes, and admission or discharge histories. A lead agency must follow the authorization process in subdivision 5 after the lead agency receives the request for authorization from the agency provider;

(3) the lead agency authorizes a temporary increase to the amount of services authorized in the agency or budget model to accommodate the participant's temporary higher need for services. Authorization for a temporary level of CFSS services is limited to the time specified by the commissioner, but shall not exceed 45 days. The level of services authorized under this clause shall have no bearing on a future authorization;

(4) a participant's medical assistance eligibility has lapsed, is then retroactively reinstated, and an authorization for CFSS services is completed based on the date of a current assessment, eligibility, and request for authorization;

(5) a third-party payer for CFSS services has denied or adjusted a payment. Authorization requests must be submitted by the provider within 20 working days of the notice of denial or adjustment. A copy of the notice must be included with the request;

(6) the commissioner has determined that a lead agency or state human services agency has made an error; or

(7) a participant enrolled in managed care experiences a temporary disenrollment from a health plan, in which case the commissioner shall accept the current health plan authorization for CFSS services for up to 60 days. The request must be received within the first 30 days of the disenrollment. If the recipient's reenrollment in managed care is after the 60 days and before 90 days, the provider shall request an additional 30-day extension of the current health plan authorization, for a total limit of 90 days from the time of disenrollment.

Sec. 12. Minnesota Statutes 2020, 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;

(1) the lead agency temporarily authorizes services in the agency-provider model as described in subdivision 5, paragraph (c);

(2) CFSS services in the agency-provider model were required to treat an emergency medical condition that if not immediately treated could cause a participant serious physical or mental disability, continuation of severe pain, or death. The CFSS agency provider must request retroactive authorization from the lead agency no later than five working days after providing the initial emergency service. The CFSS agency provider must be able to substantiate the emergency through documentation such as reports, notes, and admission or discharge histories. A lead agency must follow the authorization process in subdivision 5 after the lead agency receives the request for authorization from the agency provider;

(3) the lead agency authorizes a temporary increase to the amount of services authorized in the agency or budget model to accommodate the participant's temporary higher need for services. Authorization for a temporary level of CFSS services is limited to the time specified by the commissioner, but shall not exceed 45 days. The level of services authorized under this clause shall have no bearing on a future authorization;

(4) a participant's medical assistance eligibility has lapsed, is then retroactively reinstated, and an authorization for CFSS services is completed based on the date of a current assessment, eligibility, and request for authorization;

(5) a third-party payer for CFSS services has denied or adjusted a payment. Authorization requests must be submitted by the provider within 20 working days of the notice of denial or adjustment. A copy of the notice must be included with the request;

(6) the commissioner has determined that a lead agency or state human services agency has made an error; or

(7) a participant enrolled in managed care experiences a temporary disenrollment from a health plan, in which case the commissioner shall accept the current health plan authorization for CFSS services for up to 60 days. The request must be received within the first 30 days of the disenrollment. If the recipient's reenrollment in managed care is after the 60 days and before 90 days, the provider shall request an additional 30-day extension of the current health plan authorization, for a total limit of 90 days from the time of disenrollment.

Sec. 67. Minnesota Statutes 2020, 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

(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, advanced practice registered nurse, or physician's assistant;

(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~~ a foster care license holder ~~in a residence for more than four participants.~~ except when the home of the person receiving services is the licensed foster care provider's primary residence;

(32) services that are the responsibility of the foster care provider under the terms of the foster care placement agreement, assessment under sections 256N.24 and 260C.4411, and administrative rules under sections 256N.24 and 260C.4411;

monitored by a Minnesota health care program enrolled physician, advanced practice registered nurse, or physician's assistant;

(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~~ a foster care license holder ~~in a residence for more than four participants.~~ except when the home of the person receiving services is the licensed foster care provider's primary residence;

(32) services that are the responsibility of the foster care provider under the terms of the foster care placement agreement, assessment under sections 256N.24 and 260C.4411, and administrative rules under sections 256N.24 and 260C.4411;

(33) services in a setting that has a licensed capacity greater than six, unless all conditions for a variance under section 245A.04, subdivision 9a, are satisfied for a sibling, as defined in section 260C.007, subdivision 32;

(34) services from a provider who owns or otherwise controls the living arrangement, except when the provider of services is related by blood, marriage, or adoption or when the provider is a licensed foster care provider who is not prohibited from providing services under clauses (31) to (33);

(35) 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 an assessed need for assistance with activities of daily living, health-related procedures, and tasks or behaviors; or

(36) services provided to a resident of a nursing facility, hospital, intermediate care facility, or health care facility licensed by the commissioner of health.

Sec. 13. Minnesota Statutes 2020, 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

(33) services in a setting that has a licensed capacity greater than six, unless all conditions for a variance under section 245A.04, subdivision 9a, are satisfied for a sibling, as defined in section 260C.007, subdivision 32;

(34) services from a provider who owns or otherwise controls the living arrangement, except when the provider of services is related by blood, marriage, or adoption or when the provider is a licensed foster care provider who is not prohibited from providing services under clauses (31) to (33);

(35) 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 an assessed need for assistance with activities of daily living, health-related procedures, and tasks or behaviors; or

(36) services provided to a resident of a nursing facility, hospital, intermediate care facility, or health care facility licensed by the commissioner of health.

Sec. 68. Minnesota Statutes 2020, 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 and that meets the requirements of subdivisions 20a, 20b, and 20c for agency-providers;

(6) report maltreatment as required under section 626.557 and chapter 260E;

(7) comply with the labor market reporting requirements described in section 256B.4912, subdivision 1a;

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

(9) maintain documentation for the requirements under subdivision 16, paragraph (e), clause (2), to qualify for an enhanced rate under this section~~.~~; and

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

Sec. 14. Minnesota Statutes 2020, 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.

(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 and that meets the requirements of subdivisions 20a, 20b, and 20c for agency-providers;

(6) report maltreatment as required under section 626.557 and chapter 260E;

(7) comply with the labor market reporting requirements described in section 256B.4912, subdivision 1a;

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

(9) maintain documentation for the requirements under subdivision 16, paragraph (e), clause (2), to qualify for an enhanced rate under this section~~.~~; and

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

Sec. 69. Minnesota Statutes 2020, 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 support 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, except all of the revenue generated by a medical assistance rate increase due to a collective bargaining agreement under section 179A.54 must be used 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~~ participants 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. 15. Minnesota Statutes 2020, 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~~.~~ within 30 days of:

(1) any support worker beginning to provide services for a participant; or

(2) any support worker beginning to provide shared services.

(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;

(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, except all of the revenue generated by a medical assistance rate increase due to a collective bargaining agreement under section 179A.54 must be used 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~~ participants 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. 70. Minnesota Statutes 2020, 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 support worker through direct observation of the support worker's performance of the job functions in a setting where the participant is using CFSS~~.~~ within 30 days of:

(1) any support worker beginning to provide services for a participant; or

(2) any support worker beginning to provide shared services.

(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

~~(4)~~ (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) the support worker begins providing shared services;

~~(2)~~ (3) there is any change in condition or a modification to the CFSS service delivery plan; or

~~(3)~~ (4) a performance review indicates that additional training is needed.

Sec. 16. Minnesota Statutes 2020, 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;

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(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 including, but not limited to~~ has all of the following forms and documents:

(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, except 100 percent of the revenue generated by a medical assistance rate increase due to a collective bargaining agreement under section 179A.54 must be used for support worker wages and benefits. 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).

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(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 including, but not limited to~~ has all of the following forms and documents:

(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, except 100 percent of the revenue generated by a medical assistance rate increase due to a collective bargaining agreement under section 179A.54 must be used for support worker wages and benefits. 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~~ and 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.~~

(d) Agency-providers shall submit all required documentation in this section 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. 17. Minnesota Statutes 2020, 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.

(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~~ and 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.~~

(d) Agency-providers shall submit all required documentation in this section 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. 72. Minnesota Statutes 2020, 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. 18. Minnesota Statutes 2020, section 256B.85, subdivision 13, is amended to read:

Subd. 13. **Budget model.** (a) Under the budget model participants exercise responsibility and control over the services and supports described and budgeted within the CFSS service delivery plan. Participants must use services specified in subdivision 13a provided by an FMS provider. Under this model, participants may use their approved service budget allocation to:

(1) directly employ support workers, and pay wages, federal and state payroll taxes, and premiums for workers' compensation, liability, and health insurance coverage; and

(2) obtain supports and goods as defined in subdivision 7.

(b) Participants who are unable to fulfill any of the functions listed in paragraph (a) may authorize a legal representative or participant's representative to do so on their behalf.

(c) If two or more participants using the budget model live in the same household and have the same worker, the participants must use the same FMS provider.

(d) If the FMS provider advises that there is a joint employer in the budget model, all participants associated with that joint employer must use the same FMS provider.

~~(c)~~ (e) The commissioner shall disenroll or exclude participants from the budget model and transfer them to the agency-provider model under, but not limited to, the following circumstances:

(1) when a participant has been restricted by the Minnesota restricted recipient program, in which case the participant may be excluded for a specified time period under Minnesota Rules, parts 9505.2160 to 9505.2245;

(2) when a participant exits the budget model during the participant's service plan year. Upon transfer, the participant shall not access the budget model for the remainder of that service plan year; or

(3) when the department determines that the participant or participant's representative or legal representative is unable to fulfill the responsibilities under the budget model, as specified in subdivision 14.

~~(d)~~ (f) A participant may appeal in writing to the department under section 256.045, subdivision 3, to contest the department's decision under paragraph ~~(c)~~ (e), clause (3), to disenroll or exclude the participant from the budget model.

(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. 73. Minnesota Statutes 2020, section 256B.85, subdivision 13, is amended to read:

Subd. 13. **Budget model.** (a) Under the budget model participants exercise responsibility and control over the services and supports described and budgeted within the CFSS service delivery plan. Participants must use services specified in subdivision 13a provided by an FMS provider. Under this model, participants may use their approved service budget allocation to:

(1) directly employ support workers, and pay wages, federal and state payroll taxes, and premiums for workers' compensation, liability, and health insurance coverage; and

(2) obtain supports and goods as defined in subdivision 7.

(b) Participants who are unable to fulfill any of the functions listed in paragraph (a) may authorize a legal representative or participant's representative to do so on their behalf.

(c) If two or more participants using the budget model live in the same household and have the same support worker, the participants must use the same FMS provider.

(d) If the FMS provider advises that there is a joint employer in the budget model, all participants associated with that joint employer must use the same FMS provider.

~~(c)~~ (e) The commissioner shall disenroll or exclude participants from the budget model and transfer them to the agency-provider model under, but not limited to, the following circumstances:

(1) when a participant has been restricted by the Minnesota restricted recipient program, in which case the participant may be excluded for a specified time period under Minnesota Rules, parts 9505.2160 to 9505.2245;

(2) when a participant exits the budget model during the participant's service plan year. Upon transfer, the participant shall not access the budget model for the remainder of that service plan year; or

(3) when the department determines that the participant or participant's representative or legal representative is unable to fulfill the responsibilities under the budget model, as specified in subdivision 14.

~~(d)~~ (f) A participant may appeal in writing to the department under section 256.045, subdivision 3, to contest the department's decision under paragraph ~~(c)~~ (e), clause (3), to disenroll or exclude the participant from the budget model.

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Sec. 19. Minnesota Statutes 2020, 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

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Sec. 74. Minnesota Statutes 2020, 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. 20. Minnesota Statutes 2020, 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.

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. 75. Minnesota Statutes 2020, 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;

(2) actively participate in planning and directing CFSS services;

(3) 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 service delivery plan;

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

(5) 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 the 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 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 must enter into a written agreement with an agency-provider or FMS on a form determined by the commissioner and maintained in the participant's file, to:

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(1) be available while care is provided using 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 goods; and

(5) in the budget model, review and sign documentation to verify worker training and development expenditures.

(h) A participant's representative may delegate 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 serving as the participant's representative satisfies the requirements 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 provider 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 who fails to provide support required by the participant must be referred to the common entry point.

Sec. 21. Minnesota Statutes 2020, section 256B.85, subdivision 15, is amended to read:

Subd. 15. **Documentation of support services provided; time sheets.** (a) CFSS services provided to a participant by a support worker employed by either an agency-provider or the participant employer must be documented daily by each support worker, on a time sheet.

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(1) be available while care is provided using 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 goods; and

(5) in the budget model, review and sign documentation to verify worker training and development expenditures.

(h) A participant's representative may delegate 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 serving as the participant's representative satisfies the requirements 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 provider 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 who fails to provide support required by the participant must be referred to the common entry point.

Sec. 76. Minnesota Statutes 2020, section 256B.85, subdivision 15, is amended to read:

Subd. 15. **Documentation of support services provided; time sheets.** (a) CFSS services provided to a participant by a support worker employed by either an agency-provider or the participant employer must be documented daily by each support worker, on a time sheet.

Time sheets may be created, submitted, and maintained electronically. Time sheets must be submitted by the support worker at least once per month to the:

(1) agency-provider when the participant is using the agency-provider model. The agency-provider must maintain a record of the time sheet and provide a copy of the time sheet to the participant; or

(2) participant and the participant's FMS provider when the participant is using the budget model. The participant and the FMS provider must maintain a record of the time sheet.

(b) The documentation on the time sheet must correspond to the participant's assessed needs within the scope of CFSS covered services. The accuracy of the time sheets must be verified by the:

(1) agency-provider when the participant is using the agency-provider model; or

(2) participant employer and the participant's FMS provider when the participant is using the budget model.

(c) The time sheet must document the time the support worker provides services to the participant. The following elements must be included in the time sheet:

(1) the support worker's full name and individual provider number;

(2) the agency-provider's name and telephone numbers, when responsible for the CFSS service delivery plan;

(3) the participant's full name;

(4) the dates within the pay period established by the agency-provider or FMS provider, including month, day, and year, and arrival and departure times with a.m. or p.m. notations for days worked within the established pay period;

(5) the covered services provided to the participant on each date of service;

(6) ~~a~~ the signature ~~line for~~ of the participant or the participant's representative and a statement that the participant's or participant's representative's signature is verification of the time sheet's accuracy;

(7) the ~~personal~~ signature of the support worker;

(8) any shared care provided, if applicable;

(9) a statement that it is a federal crime to provide false information on CFSS billings for medical assistance payments; and

(10) dates and location of participant stays in a hospital, care facility, or incarceration occurring within the established pay period.

Time sheets may be created, submitted, and maintained electronically. Time sheets must be submitted by the support worker at least once per month to the:

(1) agency-provider when the participant is using the agency-provider model. The agency-provider must maintain a record of the time sheet and provide a copy of the time sheet to the participant; or

(2) participant and the participant's FMS provider when the participant is using the budget model. The participant and the FMS provider must maintain a record of the time sheet.

(b) The documentation on the time sheet must correspond to the participant's assessed needs within the scope of CFSS covered services. The accuracy of the time sheets must be verified by the:

(1) agency-provider when the participant is using the agency-provider model; or

(2) participant employer and the participant's FMS provider when the participant is using the budget model.

(c) The time sheet must document the time the support worker provides services to the participant. The following elements must be included in the time sheet:

(1) the support worker's full name and individual provider number;

(2) the agency-provider's name and telephone numbers, when responsible for the CFSS service delivery plan;

(3) the participant's full name;

(4) the dates within the pay period established by the agency-provider or FMS provider, including month, day, and year, and arrival and departure times with a.m. or p.m. notations for days worked within the established pay period;

(5) the covered services provided to the participant on each date of service;

(6) ~~a~~ the signature ~~line for~~ of the participant or the participant's representative and a statement that the participant's or participant's representative's signature is verification of the time sheet's accuracy;

(7) the ~~personal~~ signature of the support worker;

(8) any shared care provided, if applicable;

(9) a statement that it is a federal crime to provide false information on CFSS billings for medical assistance payments; and

(10) dates and location of participant stays in a hospital, care facility, or incarceration occurring within the established pay period.

Sec. 22. Minnesota Statutes 2020, section 256B.85, subdivision 17a, is amended to read:

Subd. 17a. **Consultation services provider qualifications and requirements.** Consultation services providers must meet the following qualifications and requirements:

(1) meet the requirements under subdivision 10, paragraph (a), excluding clauses (4) and (5);

(2) are under contract with the department;

(3) are not the FMS provider, the lead agency, or the CFSS or home and community-based services waiver vendor or agency-provider to the participant;

(4) meet the service standards as established by the commissioner;

(5) have proof of surety bond coverage. Upon new enrollment, or if the consultation service provider's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the consultation service 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 consultation service 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;

~~(5)~~ (6) employ lead professional staff with a minimum of ~~three~~ two years of experience in providing services such as support planning, support broker, case management or care coordination, or consultation services and consumer education to participants using a self-directed program using FMS under medical assistance;

(7) report maltreatment as required under chapter 260E and section 626.557;

~~(6)~~ (8) comply with medical assistance provider requirements;

~~(7)~~ (9) understand the CFSS program and its policies;

~~(8)~~ (10) are knowledgeable about self-directed principles and the application of the person-centered planning process;

~~(9)~~ (11) have general knowledge of the FMS provider duties and the vendor fiscal/employer agent model, including all applicable federal, state, and local laws and regulations regarding tax, labor, employment, and liability and workers' compensation coverage for household workers; and

~~(10)~~ (12) have all employees, including lead professional staff, staff in management and supervisory positions, and owners of the agency who are active in the day-to-day management and operations of the agency, complete training as specified in the contract with the department.

Sec. 77. Minnesota Statutes 2020, section 256B.85, subdivision 17a, is amended to read:

Subd. 17a. **Consultation services provider qualifications and requirements.** Consultation services providers must meet the following qualifications and requirements:

(1) meet the requirements under subdivision 10, paragraph (a), excluding clauses (4) and (5);

(2) are under contract with the department;

(3) are not the FMS provider, the lead agency, or the CFSS or home and community-based services waiver vendor or agency-provider to the participant;

(4) meet the service standards as established by the commissioner;

(5) have proof of surety bond coverage. Upon new enrollment, or if the consultation service provider's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the consultation service 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 consultation service 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;

~~(5)~~ (6) employ lead professional staff with a minimum of ~~three~~ two years of experience in providing services such as support planning, support broker, case management or care coordination, or consultation services and consumer education to participants using a self-directed program using FMS under medical assistance;

(7) report maltreatment as required under chapter 260E and section 626.557;

~~(6)~~ (8) comply with medical assistance provider requirements;

~~(7)~~ (9) understand the CFSS program and its policies;

~~(8)~~ (10) are knowledgeable about self-directed principles and the application of the person-centered planning process;

~~(9)~~ (11) have general knowledge of the FMS provider duties and the vendor fiscal/employer agent model, including all applicable federal, state, and local laws and regulations regarding tax, labor, employment, and liability and workers' compensation coverage for household workers; and

~~(10)~~ (12) have all employees, including lead professional staff, staff in management and supervisory positions, and owners of the agency who are active in the day-to-day management and operations of the agency, complete training as specified in the contract with the department.

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Sec. 23. Minnesota Statutes 2020, 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, including health-related tasks, identified in the plan through education, training, and work experience relevant to the person's assessed needs; and

~~(3)~~ (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;

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Sec. 78. Minnesota Statutes 2020, 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, including health-related tasks, identified in the plan through education, training, and work experience relevant to the person's assessed needs; and

~~(3)~~ (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~~ the rate set by the commissioner per annual service agreement, unless approved by the department.

Sec. 24. Minnesota Statutes 2020, section 256B.85, subdivision 20b, is amended to read:

Subd. 20b. **Service-related rights under an agency-provider.** A participant receiving CFSS from an agency-provider has service-related rights to:

(1) participate in and approve the initial development and ongoing modification and evaluation of CFSS services provided to the participant;

(2) refuse or terminate services and be informed of the consequences of refusing or terminating services;

(3) before services are initiated, be told the limits to the services available from the agency-provider, including the agency-provider's knowledge, skill, and ability to meet the participant's needs identified in the CFSS service delivery plan;

(4) a coordinated transfer of services when there will be a change in the agency-provider;

(5) before services are initiated, be told what the agency-provider charges for the services;

(6) before services are initiated, be told to what extent payment may be expected from health insurance, public programs, or other sources, if known; and what charges the participant may be responsible for paying;

(7) receive services from an individual who is competent and trained, who has professional certification or licensure, as required, and who meets additional qualifications identified in the participant's CFSS service delivery plan;

(8) have the participant's preferences for support workers identified and documented, and have those preferences met when possible; and

(9) before services are initiated, be told the choices that are available from the agency-provider for meeting the participant's assessed needs identified in the CFSS service delivery plan, including but not limited to which support worker staff will be providing services ~~and~~, the proposed frequency and schedule of visits, and any agreements for shared services.

Sec. 25. Minnesota Statutes 2020, section 256B.85, subdivision 23, is amended to read:

Subd. 23. **Commissioner's access.** (a) When the commissioner is investigating a possible overpayment of Medicaid funds, the commissioner must be given immediate access without

(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~~ the limit set by the commissioner per annual service agreement, unless approved by the department.

Sec. 79. Minnesota Statutes 2020, section 256B.85, subdivision 20b, is amended to read:

Subd. 20b. **Service-related rights under an agency-provider.** A participant receiving CFSS from an agency-provider has service-related rights to:

(1) participate in and approve the initial development and ongoing modification and evaluation of CFSS services provided to the participant;

(2) refuse or terminate services and be informed of the consequences of refusing or terminating services;

(3) before services are initiated, be told the limits to the services available from the agency-provider, including the agency-provider's knowledge, skill, and ability to meet the participant's needs identified in the CFSS service delivery plan;

(4) a coordinated transfer of services when there will be a change in the agency-provider;

(5) before services are initiated, be told what the agency-provider charges for the services;

(6) before services are initiated, be told to what extent payment may be expected from health insurance, public programs, or other sources, if known; and what charges the participant may be responsible for paying;

(7) receive services from an individual who is competent and trained, who has professional certification or licensure, as required, and who meets additional qualifications identified in the participant's CFSS service delivery plan;

(8) have the participant's preferences for support workers identified and documented, and have those preferences met when possible; and

(9) before services are initiated, be told the choices that are available from the agency-provider for meeting the participant's assessed needs identified in the CFSS service delivery plan, including but not limited to which support worker staff will be providing services ~~and~~, the proposed frequency and schedule of visits, and any agreements for shared services.

Sec. 80. Minnesota Statutes 2020, section 256B.85, subdivision 23, is amended to read:

Subd. 23. **Commissioner's access.** (a) When the commissioner is investigating a possible overpayment of Medicaid funds, the commissioner must be given immediate access without

prior notice to the agency-provider, consultation services provider, or FMS provider's office during regular business hours and to documentation and records related to services provided and submission of claims for services provided. ~~Denying the commissioner access to records is cause for immediate suspension of payment and terminating~~ If the ~~agency-provider's enrollment or~~ agency-provider, FMS ~~provider's enrollment~~ provider, or consultation services provider denies the commissioner access to records, the provider's payment may be immediately suspended or the provider's enrollment may be terminated according to section 256B.064 ~~or terminating the consultation services provider contract~~.

(b) The commissioner has the authority to request proof of compliance with laws, rules, and policies from agency-providers, consultation services providers, FMS providers, and participants.

(c) When relevant to an investigation conducted by the commissioner, the commissioner must be given access to the business office, documents, and records of the agency-provider, consultation services provider, or FMS provider, including records maintained in electronic format; participants served by the program; and staff during regular business hours. The commissioner must be given access without prior notice and as often as the commissioner considers necessary if the commissioner is investigating an alleged violation of applicable laws or rules. The commissioner may request and shall receive assistance from lead agencies and other state, county, and municipal agencies and departments. The commissioner's access includes being allowed to photocopy, photograph, and make audio and video recordings at the commissioner's expense.

Sec. 26. Minnesota Statutes 2020, section 256B.85, subdivision 23a, is amended to read:

Subd. 23a. **Sanctions; information for participants upon termination of services.** (a) The commissioner may withhold payment from the provider or suspend or terminate the provider enrollment number if the provider fails to comply fully with applicable laws or rules. The provider has the right to appeal the decision of the commissioner under section 256B.064.

(b) Notwithstanding subdivision 13, paragraph (c), if a participant employer fails to comply fully with applicable laws or rules, the commissioner may disenroll the participant from the budget model. A participant may appeal in writing to the department under section 256.045, subdivision 3, to contest the department's decision to disenroll the participant from the budget model.

(c) Agency-providers of CFSS services or FMS providers must provide each participant with a copy of participant protections in subdivision 20c at least 30 days prior to terminating services to a participant, if the termination results from sanctions under this subdivision or section 256B.064, such as a payment withhold or a suspension or termination of the provider enrollment number. If a CFSS agency-provider ~~or~~, FMS provider, or consultation services provider determines it is unable to continue providing services to a participant because of an action under this subdivision or section 256B.064, the agency-provider ~~or~~, FMS provider, or consultation services provider must notify the participant, the participant's representative,

prior notice to the agency-provider, consultation services provider, or FMS provider's office during regular business hours and to documentation and records related to services provided and submission of claims for services provided. ~~Denying the commissioner access to records is cause for immediate suspension of payment and terminating~~ If the ~~agency-provider's enrollment or~~ agency-provider, FMS ~~provider's enrollment~~ provider, or consultation services provider denies the commissioner access to records, the provider's payment may be immediately suspended or the provider's enrollment may be terminated according to section 256B.064 ~~or terminating the consultation services provider contract~~.

(b) The commissioner has the authority to request proof of compliance with laws, rules, and policies from agency-providers, consultation services providers, FMS providers, and participants.

(c) When relevant to an investigation conducted by the commissioner, the commissioner must be given access to the business office, documents, and records of the agency-provider, consultation services provider, or FMS provider, including records maintained in electronic format; participants served by the program; and staff during regular business hours. The commissioner must be given access without prior notice and as often as the commissioner considers necessary if the commissioner is investigating an alleged violation of applicable laws or rules. The commissioner may request and shall receive assistance from lead agencies and other state, county, and municipal agencies and departments. The commissioner's access includes being allowed to photocopy, photograph, and make audio and video recordings at the commissioner's expense.

Sec. 81. Minnesota Statutes 2020, section 256B.85, subdivision 23a, is amended to read:

Subd. 23a. **Sanctions; information for participants upon termination of services.** (a) The commissioner may withhold payment from the provider or suspend or terminate the provider enrollment number if the provider fails to comply fully with applicable laws or rules. The provider has the right to appeal the decision of the commissioner under section 256B.064.

(b) Notwithstanding subdivision 13, paragraph (c), if a participant employer fails to comply fully with applicable laws or rules, the commissioner may disenroll the participant from the budget model. A participant may appeal in writing to the department under section 256.045, subdivision 3, to contest the department's decision to disenroll the participant from the budget model.

(c) Agency-providers of CFSS services or FMS providers must provide each participant with a copy of participant protections in subdivision 20c at least 30 days prior to terminating services to a participant, if the termination results from sanctions under this subdivision or section 256B.064, such as a payment withhold or a suspension or termination of the provider enrollment number. If a CFSS agency-provider ~~or~~, FMS provider, or consultation services provider determines it is unable to continue providing services to a participant because of an action under this subdivision or section 256B.064, the agency-provider ~~or~~, FMS provider, or consultation services provider must notify the participant, the participant's representative,

and the commissioner 30 days prior to terminating services to the participant, and must assist the commissioner and lead agency in supporting the participant in transitioning to another CFSS agency-provider ~~or,~~ FMS provider, or consultation services provider of the participant's choice.

(d) In the event the commissioner withholds payment from a CFSS agency-provider ~~or,~~ FMS provider, or consultation services provider, or suspends or terminates a provider enrollment number of a CFSS agency-provider ~~or,~~ FMS provider, or consultation services provider under this subdivision or section 256B.064, the commissioner may inform the Office of Ombudsman for Long-Term Care and the lead agencies for all participants with active service agreements with the agency-provider ~~or,~~ FMS provider, or consultation services provider. At the commissioner's request, the lead agencies must contact participants to ensure that the participants are continuing to receive needed care, and that the participants have been given free choice of agency-provider ~~or,~~ FMS provider, or consultation services provider if they transfer to another CFSS agency-provider ~~or,~~ FMS provider, or consultation services provider. In addition, the commissioner or the commissioner's delegate may directly notify participants who receive care from the agency-provider ~~or,~~ FMS provider, or consultation services provider that payments have been or will be withheld or that the provider's participation in medical assistance has been or will be suspended or terminated, if the commissioner determines that the notification is necessary to protect the welfare of the participants.

and the commissioner 30 days prior to terminating services to the participant, and must assist the commissioner and lead agency in supporting the participant in transitioning to another CFSS agency-provider ~~or,~~ FMS provider, or consultation services provider of the participant's choice.

(d) In the event the commissioner withholds payment from a CFSS agency-provider ~~or,~~ FMS provider, or consultation services provider, or suspends or terminates a provider enrollment number of a CFSS agency-provider ~~or,~~ FMS provider, or consultation services provider under this subdivision or section 256B.064, the commissioner may inform the Office of Ombudsman for Long-Term Care and the lead agencies for all participants with active service agreements with the agency-provider ~~or,~~ FMS provider, or consultation services provider. At the commissioner's request, the lead agencies must contact participants to ensure that the participants are continuing to receive needed care, and that the participants have been given free choice of agency-provider ~~or,~~ FMS provider, or consultation services provider if they transfer to another CFSS agency-provider ~~or,~~ FMS provider, or consultation services provider. In addition, the commissioner or the commissioner's delegate may directly notify participants who receive care from the agency-provider ~~or,~~ FMS provider, or consultation services provider that payments have been or will be withheld or that the provider's participation in medical assistance has been or will be suspended or terminated, if the commissioner determines that the notification is necessary to protect the welfare of the participants.

Sec. 82. Minnesota Statutes 2020, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. **Covered health services.** (a) "Covered health services" means the health services reimbursed under chapter 256B, with the exception of special education services, home care nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation services, personal care assistance and case management services, community first services and supports under Minnesota Statutes, section 256B.85, behavioral health home services under section 256B.0757, housing stabilization services under section 256B.051, and nursing home or intermediate care facilities services.

(b) No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

(c) Covered health services shall be expanded as provided in this section.

(d) For the purposes of covered health services under this section, "child" means an individual younger than 19 years of age.

Sec. 83. **REVISOR INSTRUCTION.**

(a) In Minnesota Statutes, sections 245A.191, paragraph (a); 245G.02, subdivision 3; 246.18, subdivision 2; 246.23, subdivision 2; 246.64, subdivision 3; 254A.03, subdivision

3; 254A.19, subdivision 4; 254B.03, subdivision 2; 254B.04, subdivision 1; 254B.05, subdivisions 1a and 4; 254B.051; 254B.06, subdivision 1; 254B.12, subdivisions 1 and 2; 254B.13, subdivisions 2a and 5; 254B.14, subdivision 5; 256L.03, subdivision 2; and 295.53, subdivision 1, the revisor of statutes must change the term "consolidated chemical dependency treatment fund" or similar terms to "behavioral health fund." The revisor may make grammatical changes related to the term change.

(b) In Minnesota Statutes, sections 245C.03, subdivision 13, and 256B.051, the revisor of statutes must change the term "housing support services" or similar terms to "housing stabilization services." The revisor may make grammatical changes related to the term change.

(c) In Minnesota Statutes, section 245C.03, subdivision 10, the revisor of statutes must change the term "group residential housing" to "housing support." The revisor may make grammatical changes related to the term change.

Sec. 84. **REPEALER.**

(a) Minnesota Statutes 2020, section 252.28, subdivisions 1 and 5, are repealed.

(b) Minnesota Statutes 2020, sections 252A.02, subdivisions 8 and 10; and 252A.21, subdivision 3, are repealed.

EFFECTIVE DATE. Paragraph (a) is effective the day following final enactment. Paragraph (b) is effective August 1, 2021.