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ARTICLE 15
COMMUNITY SUPPORTS POLICY

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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

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

521.17 (i) a child receiving child protective services;

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

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

521.20 (iv) a child found to be delinquent; or

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

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

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

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

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

522.10 (1) training in the administration of the instrument;

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

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

522.13 (4) the parental consent requirement; and

522.14 (5) providing respect for families and cultural values.

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

522.18 The administration of the screening shall safeguard the privacy of children receiving the
 522.19 screening and their families and shall comply with the Minnesota Government Data Practices
 522.20 Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of
 522.21 1996, Public Law 104-191. Screening results ~~shall be considered private data and the~~
 522.22 ~~commissioner shall not collect individual screening results~~ are classified as private data on
 522.23 individuals, as defined by section 13.02, subdivision 12. The county board or Tribal nation
 522.24 may provide the commissioner with access to the screening results for the purposes of
 522.25 program evaluation and improvement.

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

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

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

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

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

523.10 (3) a representative of the Department of Health;

523.11 ~~(3)~~ (4) one member of each of the following professions:

523.12 (i) psychiatry;

523.13 (ii) psychology;

523.14 (iii) social work;

523.15 (iv) nursing;

523.16 (v) marriage and family therapy; and

523.17 (vi) professional clinical counseling;

523.18 ~~(4)~~ (5) one representative from each of the following advocacy groups: Mental Health
 523.19 Association of Minnesota, NAMI-MN, ~~Mental Health Consumer/Survivor Network of~~
 523.20 ~~Minnesota, and~~ Minnesota Disability Law Center, American Indian Mental Health Advisory
 523.21 Council, and a consumer-run mental health advocacy group;

523.22 ~~(5)~~ (6) providers of mental health services;

- 523.23 ~~(6)~~ (7) consumers of mental health services;
- 523.24 ~~(7)~~ (8) family members of persons with mental illnesses;
- 523.25 ~~(8)~~ (9) legislators;
- 523.26 ~~(9)~~ (10) social service agency directors;
- 523.27 ~~(10)~~ (11) county commissioners; and
- 523.28 ~~(11)~~ (12) other members reflecting a broad range of community interests, including
- 523.29 family physicians, or members as the United States Secretary of Health and Human Services
- 523.30 may prescribe by regulation or as may be selected by the governor.
- 524.1 (b) The council shall select a chair. Terms, compensation, and removal of members and
- 524.2 filling of vacancies are governed by section 15.059. Notwithstanding provisions of section
- 524.3 15.059, the council and its subcommittee on children's mental health do not expire. The
- 524.4 commissioner of human services shall provide staff support and supplies to the council.
- 524.5 Sec. 3. Minnesota Statutes 2020, section 252.43, is amended to read:
- 524.6 **252.43 COMMISSIONER'S DUTIES.**
- 524.7 (a) The commissioner shall supervise lead agencies' provision of day services to adults
- 524.8 with disabilities. The commissioner shall:
- 524.9 (1) determine the need for day ~~services~~ programs under ~~section~~ sections 256B.4914 and
- 524.10 252.41 to 252.46;
- 524.11 (2) establish payment rates as provided under section 256B.4914;
- 524.12 (3) adopt rules for the administration and provision of day services under sections
- 524.13 245A.01 to 245A.16~~;~~ 252.28, subdivision 2~~;~~ or 252.41 to 252.46~~;~~ or Minnesota Rules,
- 524.14 parts 9525.1200 to 9525.1330;
- 524.15 (4) enter into interagency agreements necessary to ensure effective coordination and
- 524.16 provision of day services;
- 524.17 (5) monitor and evaluate the costs and effectiveness of day services; and
- 524.18 (6) provide information and technical help to lead agencies and vendors in their
- 524.19 administration and provision of day services.
- 524.20 (b) A determination of need in paragraph (a), clause (1), shall not be required for a
- 524.21 change in day service provider name or ownership.
- 524.22 **EFFECTIVE DATE.** This section is effective the day following final enactment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

525.29 (1) the person subject to guardianship, protected person, or respondent;
525.30 (2) a nominated guardian or conservator;
526.1 (3) a legal representative;
526.2 (4) the spouse; parent, including stepparent; adult children, including adult stepchildren
526.3 of a living spouse; and siblings. If no such persons are living or can be located, the next of
526.4 kin of the person subject to public guardianship or the respondent is an interested person;
526.5 (5) a representative of a state ombudsman's office or a federal protection and advocacy
526.6 program that has notified the commissioner or lead agency that it has a matter regarding
526.7 the protected person subject to guardianship, person subject to conservatorship, or respondent;
526.8 and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

529.10 **252A.05 COMMISSIONER'S PETITION FOR APPOINTMENT AS PUBLIC**
529.11 **GUARDIAN ~~OR PUBLIC CONSERVATOR~~.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

535.4 **252A.12 APPOINTMENT OF ~~CONSERVATOR~~ PUBLIC GUARDIAN NOT A**
535.5 **FINDING OF INCOMPETENCY.**

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

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

535.13 **252A.16 ANNUAL REVIEW.**

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

535.22 Subd. 2. **Assessment of need for continued guardianship.** The commissioner shall
535.23 annually review the legal status of each ~~ward~~ person subject to public guardianship in light
535.24 of the progress indicated in the annual review. If the commissioner determines the ~~ward~~
535.25 person subject to public guardianship is no longer in need of public guardianship or
535.26 ~~conservatorship~~ or is capable of functioning under a less restrictive ~~conservatorship~~
535.27 guardianship, the commissioner or local agency shall petition the court pursuant to section
535.28 252A.19 to restore the ~~ward~~ person subject to public guardianship to capacity or for a
535.29 modification of the court's previous order.

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

536.2 **252A.17 EFFECT OF SUCCESSION IN OFFICE.**

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

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

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

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

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

536.14 (3) for an order to appoint a guardian or conservator under sections 524.5-101 to
536.15 524.5-502 ~~or to;~~

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

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

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

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

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

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

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

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

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

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

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

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

537.13 **252A.20 COSTS OF HEARINGS.**

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

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

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

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

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

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

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

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

538.19 Subd. 2. **Chemical dependency fund payment.** (a) Payment from the chemical
538.20 dependency fund is limited to payments for services identified in section 254B.05, other
538.21 than detoxification licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, that, if
538.22 located outside of federally recognized tribal lands, would be required to be licensed by the
538.23 commissioner as a chemical dependency treatment or rehabilitation program under sections
538.24 245A.01 to 245A.16, and services other than detoxification provided in another state that
538.25 would be required to be licensed as a chemical dependency program if the program were
538.26 in the state. Out of state vendors must also provide the commissioner with assurances that
538.27 the program complies substantially with state licensing requirements and possesses all
538.28 licenses and certifications required by the host state to provide chemical dependency
538.29 treatment. Vendors receiving payments from the chemical dependency fund must not require

538.30 co-payment from a recipient of benefits for services provided under this subdivision. The
538.31 vendor is prohibited from using the client's public benefits to offset the cost of services paid
538.32 under this section. The vendor shall not require the client to use public benefits for room
538.33 or board costs. This includes but is not limited to cash assistance benefits under chapters
539.1 119B, 256D, and 256J, or SNAP benefits. Retention of SNAP benefits is a right of a client
539.2 receiving services through the consolidated chemical dependency treatment fund or through
539.3 state contracted managed care entities. Payment from the chemical dependency fund shall
539.4 be made for necessary room and board costs provided by vendors meeting the criteria under
539.5 section 254B.05, subdivision 1a, or in a community hospital licensed by the commissioner
539.6 of health according to sections 144.50 to 144.56 to a client who is:

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

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

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

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

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

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

- 540.1 Sec. 50. Minnesota Statutes 2020, section 256B.051, subdivision 3, is amended to read:
- 540.2 Subd. 3. **Eligibility.** An individual with a disability is eligible for housing ~~support~~
540.3 stabilization services if the individual:
- 540.4 (1) is 18 years of age or older;
- 540.5 (2) is enrolled in medical assistance;
- 540.6 (3) has an assessment of functional need that determines a need for services due to
540.7 limitations caused by the individual's disability;
- 540.8 (4) resides in or plans to transition to a community-based setting as defined in Code of
540.9 Federal Regulations, title 42, section 441.301 (c); and
- 540.10 (5) has housing instability evidenced by:
- 540.11 (i) being homeless or at-risk of homelessness;
- 540.12 (ii) being in the process of transitioning from, or having transitioned in the past six
540.13 months from, an institution or licensed or registered setting;
- 540.14 (iii) being eligible for waiver services under chapter 256S or section 256B.092 or
540.15 256B.49; or
- 540.16 (iv) having been identified by a long-term care consultation under section 256B.0911
540.17 as at risk of institutionalization.
- 540.18 Sec. 51. Minnesota Statutes 2020, section 256B.051, subdivision 5, is amended to read:
- 540.19 Subd. 5. **Housing ~~support~~ stabilization services.** (a) Housing ~~support~~ stabilization
540.20 services include housing transition services and housing and tenancy sustaining services.
- 540.21 (b) Housing transition services are defined as:
- 540.22 (1) tenant screening and housing assessment;
- 540.23 (2) assistance with the housing search and application process;
- 540.24 (3) identifying resources to cover onetime moving expenses;
- 540.25 (4) ensuring a new living arrangement is safe and ready for move-in;
- 540.26 (5) assisting in arranging for and supporting details of a move; and
- 540.27 (6) developing a housing support crisis plan.
- 540.28 (c) Housing and tenancy sustaining services include:
- 541.1 (1) prevention and early identification of behaviors that may jeopardize continued stable
541.2 housing;

- 541.3 (2) education and training on roles, rights, and responsibilities of the tenant and the
541.4 property manager;
- 541.5 (3) coaching to develop and maintain key relationships with property managers and
541.6 neighbors;
- 541.7 (4) advocacy and referral to community resources to prevent eviction when housing is
541.8 at risk;
- 541.9 (5) assistance with housing recertification process;
- 541.10 (6) coordination with the tenant to regularly review, update, and modify the housing
541.11 support and crisis plan; and
- 541.12 (7) continuing training on being a good tenant, lease compliance, and household
541.13 management.
- 541.14 (d) A housing ~~support~~ stabilization service may include person-centered planning for
541.15 people who are not eligible to receive person-centered planning through any other service,
541.16 if the person-centered planning is provided by a consultation service provider that is under
541.17 contract with the department and enrolled as a Minnesota health care program.
- 541.18 Sec. 52. Minnesota Statutes 2020, section 256B.051, subdivision 6, is amended to read:
- 541.19 Subd. 6. **Provider qualifications and duties.** A provider eligible for reimbursement
541.20 under this section shall:
- 541.21 (1) enroll as a medical assistance Minnesota health care program provider and meet all
541.22 applicable provider standards and requirements;
- 541.23 (2) demonstrate compliance with federal and state laws and policies for housing ~~support~~,
541.24 stabilization services as determined by the commissioner;
- 541.25 (3) comply with background study requirements under chapter 245C and maintain
541.26 documentation of background study requests and results; ~~and~~
- 541.27 (4) directly provide housing ~~support~~ stabilization services and not use a subcontractor
541.28 or reporting agent; and
- 541.29 (5) complete annual vulnerable adult training.
- 542.1 Sec. 53. Minnesota Statutes 2020, section 256B.051, subdivision 7, is amended to read:
- 542.2 Subd. 7. **Housing support supplemental service rates.** Supplemental service rates for
542.3 individuals in settings according to sections 144D.025, 256I.04, subdivision 3, paragraph
542.4 (a), clause (3), and 256I.05, subdivision 1g, shall be reduced by one-half over a two-year
542.5 period. This reduction only applies to supplemental service rates for individuals eligible for
542.6 housing ~~support~~ stabilization services under this section.

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

586.4 Subd. 6. **Service standards.** The standards in this subdivision apply to intensive

586.5 nonresidential rehabilitative mental health services.

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

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

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

586.9 (d) The initial functional assessment must be completed within ten days of intake and

586.10 updated at least every six months or prior to discharge from the service, whichever comes

586.11 first.

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

586.13 the individual treatment plan must:

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

586.15 (2) identify goals and objectives of treatment, a treatment strategy, a schedule for

586.16 accomplishing treatment goals and objectives, and the individuals responsible for providing

586.17 treatment services and supports;

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

542.8 to read:

542.9 Subd. 8. **Documentation requirements.** (a) Documentation may be collected and

542.10 maintained electronically or in paper form by providers and must be produced upon request

542.11 by the commissioner.

542.12 (b) Documentation of a delivered service must be in English and must be legible according

542.13 to the standard of a reasonable person.

542.14 (c) If the service is reimbursed at an hourly or specified minute-based rate, each

542.15 documentation of the provision of a service, unless otherwise specified, must include:

542.16 (1) the date the documentation occurred;

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

542.18 (3) the start and stop times with a.m. and p.m. designations, except for person-centered

542.19 planning services described under subdivision 5, paragraph (d);

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

542.21 (5) the name, signature, and title, if any, of the provider of service. If the service is

542.22 provided by multiple staff members, the provider may designate a staff member responsible

542.23 for verifying services and completing the documentation required by this paragraph.

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

542.25 Subd. 6. **Service standards.** The standards in this subdivision apply to intensive

542.26 nonresidential rehabilitative mental health services.

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

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

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

543.1 (d) The initial functional assessment must be completed within ten days of intake and

543.2 updated at least every six months or prior to discharge from the service, whichever comes

543.3 first.

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

543.5 the individual treatment plan must:

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

543.7 (2) identify goals and objectives of treatment, a treatment strategy, a schedule for

543.8 accomplishing treatment goals and objectives, and the individuals responsible for providing

543.9 treatment services and supports;

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

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

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

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

587.1 (7) be completed in consultation with the client's current therapist and key providers and
587.2 provide for ongoing consultation with the client's current therapist to ensure therapeutic
587.3 continuity and to facilitate the client's return to the community. For clients under the age of
587.4 18, the treatment team must consult with parents and guardians in developing the treatment
587.5 plan;

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

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

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

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

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

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

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

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

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

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

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

543.23 (7) be completed in consultation with the client's current therapist and key providers and
543.24 provide for ongoing consultation with the client's current therapist to ensure therapeutic
543.25 continuity and to facilitate the client's return to the community. For clients under the age of
543.26 18, the treatment team must consult with parents and guardians in developing the treatment
543.27 plan;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

545.8 (2) documentation demonstrating that a vehicle and a driver meet the ~~standards determined~~
 545.9 ~~by the Department of Human Services on vehicle and driver qualifications in section~~
 545.10 ~~256B.0625, subdivision 17, paragraph (c) transportation waiver service provider standards~~
 545.11 ~~and qualifications according to the federally approved waiver plan.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

590.1 (f) Effective for services rendered on or after January 1, 2012, the commissioner shall
590.2 include as part of the performance targets described in paragraph (c) a reduction in the plan's
590.3 hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as
590.4 determined by the commissioner. To earn the return of the withhold each year, the managed
590.5 care plan or county-based purchasing plan must achieve a qualifying reduction of no less
590.6 than five percent of the plan's hospital admission rate for medical assistance and
590.7 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
590.8 28, compared to the previous calendar year until the final performance target is reached.
590.9 When measuring performance, the commissioner must consider the difference in health risk
590.10 in a managed care or county-based purchasing plan's membership in the baseline year
590.11 compared to the measurement year, and work with the managed care or county-based
590.12 purchasing plan to account for differences that they agree are significant.

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

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

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

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

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

547.7 (f) Effective for services rendered on or after January 1, 2012, the commissioner shall
547.8 include as part of the performance targets described in paragraph (c) a reduction in the plan's
547.9 hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as
547.10 determined by the commissioner. To earn the return of the withhold each year, the managed
547.11 care plan or county-based purchasing plan must achieve a qualifying reduction of no less
547.12 than five percent of the plan's hospital admission rate for medical assistance and
547.13 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
547.14 28, compared to the previous calendar year until the final performance target is reached.
547.15 When measuring performance, the commissioner must consider the difference in health risk
547.16 in a managed care or county-based purchasing plan's membership in the baseline year
547.17 compared to the measurement year, and work with the managed care or county-based
547.18 purchasing plan to account for differences that they agree are significant.

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

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

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

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

591.7 The withhold described in this paragraph must continue for each consecutive contract
591.8 period until the plan's subsequent hospitalization rate for medical assistance and
591.9 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
591.10 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year
591.11 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall
591.12 accept payment withholds that must be returned to the hospitals if the performance target
591.13 is achieved.

591.14 (h) Effective for services rendered on or after January 1, 2013, through December 31,
591.15 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under
591.16 this section and county-based purchasing plan payments under section 256B.692 for the
591.17 prepaid medical assistance program. The withheld funds must be returned no sooner than
591.18 July 1 and no later than July 31 of the following year. The commissioner may exclude
591.19 special demonstration projects under subdivision 23.

591.20 (i) Effective for services rendered on or after January 1, 2014, the commissioner shall
591.21 withhold three percent of managed care plan payments under this section and county-based
591.22 purchasing plan payments under section 256B.692 for the prepaid medical assistance
591.23 program. The withheld funds must be returned no sooner than July 1 and no later than July
591.24 31 of the following year. The commissioner may exclude special demonstration projects
591.25 under subdivision 23.

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

591.29 (k) Contracts between the commissioner and a prepaid health plan are exempt from the
591.30 set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and
591.31 7.

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

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

548.12 The withhold described in this paragraph must continue for each consecutive contract
548.13 period until the plan's subsequent hospitalization rate for medical assistance and
548.14 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
548.15 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year
548.16 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall
548.17 accept payment withholds that must be returned to the hospitals if the performance target
548.18 is achieved.

548.19 (h) Effective for services rendered on or after January 1, 2013, through December 31,
548.20 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under
548.21 this section and county-based purchasing plan payments under section 256B.692 for the
548.22 prepaid medical assistance program. The withheld funds must be returned no sooner than
548.23 July 1 and no later than July 31 of the following year. The commissioner may exclude
548.24 special demonstration projects under subdivision 23.

548.25 (i) Effective for services rendered on or after January 1, 2014, the commissioner shall
548.26 withhold three percent of managed care plan payments under this section and county-based
548.27 purchasing plan payments under section 256B.692 for the prepaid medical assistance
548.28 program. The withheld funds must be returned no sooner than July 1 and no later than July
548.29 31 of the following year. The commissioner may exclude special demonstration projects
548.30 under subdivision 23.

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

549.1 (k) Contracts between the commissioner and a prepaid health plan are exempt from the
549.2 set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and
549.3 7.

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

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

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

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

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

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

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

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

593.1 Sec. 4. Minnesota Statutes 2020, section 256B.85, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

550.5 Sec. 59. Minnesota Statutes 2020, section 256B.85, subdivision 2, is amended to read:

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

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

593.6 (1) dressing, including assistance with choosing, applying, and changing clothing and
 593.7 applying special appliances, wraps, or clothing;

593.8 (2) grooming, including assistance with basic hair care, oral care, shaving, applying
 593.9 cosmetics and deodorant, and care of eyeglasses and hearing aids. Grooming includes nail
 593.10 care, except for recipients who are diabetic or have poor circulation;

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

593.12 (4) eating, including assistance with hand washing and applying orthotics required for
 593.13 eating, transfers, or feeding;

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

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

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

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

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

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

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

594.1 (f) "Complex health-related needs" means an intervention listed in clauses (1) to (8) that
 594.2 has been ordered by a physician, advanced practice registered nurse, or physician's assistant
 594.3 and is specified in a community support plan, including:

594.4 (1) tube feedings requiring:

594.5 (i) a gastrojejunostomy tube; or

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

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

550.10 (1) dressing, including assistance with choosing, applying, and changing clothing and
 550.11 applying special appliances, wraps, or clothing;

550.12 (2) grooming, including assistance with basic hair care, oral care, shaving, applying
 550.13 cosmetics and deodorant, and care of eyeglasses and hearing aids. Grooming includes nail
 550.14 care, except for recipients who are diabetic or have poor circulation;

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

550.16 (4) eating, including assistance with hand washing and applying orthotics required for
 550.17 eating, transfers, or feeding;

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

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

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

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

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

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

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

551.7 (f) "Complex health-related needs" means an intervention listed in clauses (1) to (8) that
 551.8 has been ordered by a physician, advanced practice registered nurse, or physician's assistant
 551.9 and is specified in a community support plan, including:

551.10 (1) tube feedings requiring:

551.11 (i) a gastrojejunostomy tube; or

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

594.7 (2) wounds described as:
594.8 (i) stage III or stage IV;
594.9 (ii) multiple wounds;
594.10 (iii) requiring sterile or clean dressing changes or a wound vac; or
594.11 (iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized
594.12 care;
594.13 (3) parenteral therapy described as:
594.14 (i) IV therapy more than two times per week lasting longer than four hours for each
594.15 treatment; or
594.16 (ii) total parenteral nutrition (TPN) daily;
594.17 (4) respiratory interventions, including:
594.18 (i) oxygen required more than eight hours per day;
594.19 (ii) respiratory vest more than one time per day;
594.20 (iii) bronchial drainage treatments more than two times per day;
594.21 (iv) sterile or clean suctioning more than six times per day;
594.22 (v) dependence on another to apply respiratory ventilation augmentation devices such
594.23 as BiPAP and CPAP; and
594.24 (vi) ventilator dependence under section 256B.0651;
594.25 (5) insertion and maintenance of catheter, including:
594.26 (i) sterile catheter changes more than one time per month;
594.27 (ii) clean intermittent catheterization, and including self-catheterization more than six
594.28 times per day; or
594.29 (iii) bladder irrigations;
595.1 (6) bowel program more than two times per week requiring more than 30 minutes to
595.2 perform each time;
595.3 (7) neurological intervention, including:
595.4 (i) seizures more than two times per week and requiring significant physical assistance
595.5 to maintain safety; or
595.6 (ii) swallowing disorders diagnosed by a physician, advanced practice registered nurse,
595.7 or physician's assistant and requiring specialized assistance from another on a daily basis;
595.8 and

551.13 (2) wounds described as:
551.14 (i) stage III or stage IV;
551.15 (ii) multiple wounds;
551.16 (iii) requiring sterile or clean dressing changes or a wound vac; or
551.17 (iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized
551.18 care;
551.19 (3) parenteral therapy described as:
551.20 (i) IV therapy more than two times per week lasting longer than four hours for each
551.21 treatment; or
551.22 (ii) total parenteral nutrition (TPN) daily;
551.23 (4) respiratory interventions, including:
551.24 (i) oxygen required more than eight hours per day;
551.25 (ii) respiratory vest more than one time per day;
551.26 (iii) bronchial drainage treatments more than two times per day;
551.27 (iv) sterile or clean suctioning more than six times per day;
551.28 (v) dependence on another to apply respiratory ventilation augmentation devices such
551.29 as BiPAP and CPAP; and
552.1 (vi) ventilator dependence under section 256B.0651;
552.2 (5) insertion and maintenance of catheter, including:
552.3 (i) sterile catheter changes more than one time per month;
552.4 (ii) clean intermittent catheterization, and including self-catheterization more than six
552.5 times per day; or
552.6 (iii) bladder irrigations;
552.7 (6) bowel program more than two times per week requiring more than 30 minutes to
552.8 perform each time;
552.9 (7) neurological intervention, including:
552.10 (i) seizures more than two times per week and requiring significant physical assistance
552.11 to maintain safety; or
552.12 (ii) swallowing disorders diagnosed by a physician, advanced practice registered nurse,
552.13 or physician's assistant and requiring specialized assistance from another on a daily basis;
552.14 and

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

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

595.16 (h) "Community first services and supports service delivery plan" or "CFSS service
595.17 delivery plan" means a written document detailing the services and supports chosen by the
595.18 participant to meet assessed needs that are within the approved CFSS service authorization,
595.19 as determined in subdivision 8. Services and supports are based on the coordinated service
595.20 and support plan identified in ~~section~~ sections 256B.092, subdivision 1b, and 256S.10.

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

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

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

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

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

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

596.13 (o) "Instrumental activities of daily living" means activities related to living independently
596.14 in the community, including but not limited to: meal planning, preparation, and cooking;

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

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

552.22 (h) "Community first services and supports service delivery plan" or "CFSS service
552.23 delivery plan" means a written document detailing the services and supports chosen by the
552.24 participant to meet assessed needs that are within the approved CFSS service authorization,
552.25 as determined in subdivision 8. Services and supports are based on the coordinated service
552.26 and support plan identified in ~~section~~ sections 256B.092, subdivision 1b, and 256S.10.

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

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

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

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

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

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

553.20 (o) "Instrumental activities of daily living" means activities related to living independently
553.21 in the community, including but not limited to: meal planning, preparation, and cooking;

596.15 shopping for food, clothing, or other essential items; laundry; housecleaning; assistance
596.16 with medications; managing finances; communicating needs and preferences during activities;
596.17 arranging supports; and assistance with traveling around and participating in the community.

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

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

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

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

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

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

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

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

597.7 (u) "Participant's representative" means a parent, family member, advocate, or other
597.8 adult authorized by the participant or participant's legal representative, if any, to serve as a
597.9 representative in connection with the provision of CFSS. ~~This authorization must be in~~
597.10 ~~writing or by another method that clearly indicates the participant's free choice and may be~~
597.11 ~~withdrawn at any time. The participant's representative must have no financial interest in~~
597.12 ~~the provision of any services included in the participant's CFSS service delivery plan and~~
597.13 ~~must be capable of providing the support necessary to assist the participant in the use of~~
597.14 ~~CFSS. If through the assessment process described in subdivision 5 a participant is~~
597.15 ~~determined to be in need of a participant's representative, one must be selected. If the~~
597.16 participant is unable to assist in the selection of a participant's representative, the legal
597.17 representative shall appoint one. ~~Two persons may be designated as a participant's~~

553.22 shopping for food, clothing, or other essential items; laundry; housecleaning; assistance
553.23 with medications; managing finances; communicating needs and preferences during activities;
553.24 arranging supports; and assistance with traveling around and participating in the community.

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

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

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

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

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

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

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

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

554.14 (u) "Participant's representative" means a parent, family member, advocate, or other
554.15 adult authorized by the participant or participant's legal representative, if any, to serve as a
554.16 representative in connection with the provision of CFSS. ~~This authorization must be in~~
554.17 ~~writing or by another method that clearly indicates the participant's free choice and may be~~
554.18 ~~withdrawn at any time. The participant's representative must have no financial interest in~~
554.19 ~~the provision of any services included in the participant's CFSS service delivery plan and~~
554.20 ~~must be capable of providing the support necessary to assist the participant in the use of~~
554.21 ~~CFSS. If through the assessment process described in subdivision 5 a participant is~~
554.22 ~~determined to be in need of a participant's representative, one must be selected. If the~~
554.23 participant is unable to assist in the selection of a participant's representative, the legal
554.24 representative shall appoint one. ~~Two persons may be designated as a participant's~~

597.18 ~~representative for reasons such as divided households and court-ordered custodies. Duties~~
 597.19 ~~of a participant's representatives may include:~~

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

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

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

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

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

597.31 (x) "Shared services" means the provision of CFSS services by the same CFSS support
 597.32 worker to two or three participants who voluntarily enter into ~~an~~ a written agreement to
 598.1 receive services at the same time ~~and~~, in the same setting by, and through the same ~~employer~~
 598.2 agency-provider or FMS provider.

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

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

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

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

598.16 (cc) "Worker training and development" means services provided according to subdivision
 598.17 18a for developing workers' skills as required by the participant's individual CFSS service
 598.18 delivery plan that are arranged for or provided by the agency-provider or purchased by the
 598.19 participant employer. These services include training, education, direct observation and
 598.20 supervision, and evaluation and coaching of job skills and tasks, including supervision of
 598.21 health-related tasks or behavioral supports.

554.25 ~~representative for reasons such as divided households and court-ordered custodies. Duties~~
 554.26 ~~of a participant's representatives may include:~~

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

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

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

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

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

555.5 (x) "Shared services" means the provision of CFSS services by the same CFSS support
 555.6 worker to two or three participants who voluntarily enter into ~~an~~ a written agreement to
 555.7 receive services at the same time ~~and~~, in the same setting by, and through the same ~~employer~~
 555.8 agency-provider or FMS provider.

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

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

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

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

555.22 (cc) "Worker training and development" means services provided according to subdivision
 555.23 18a for developing workers' skills as required by the participant's individual CFSS service
 555.24 delivery plan that are arranged for or provided by the agency-provider or purchased by the
 555.25 participant employer. These services include training, education, direct observation and
 555.26 supervision, and evaluation and coaching of job skills and tasks, including supervision of
 555.27 health-related tasks or behavioral supports.

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

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

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

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

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

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

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

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

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

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

599.6 (c) A pregnant woman eligible for medical assistance under section 256B.055, subdivision
599.7 6, is eligible for CFSS without federal financial participation if the woman: (1) is eligible
599.8 for CFSS under paragraphs (a) and (b); and (2) does not meet institutional level of care, as
599.9 determined under section 256B.0911.

599.10 Sec. 6. Minnesota Statutes 2020, section 256B.85, subdivision 4, is amended to read:

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

599.14 Sec. 7. Minnesota Statutes 2020, section 256B.85, subdivision 5, is amended to read:

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

599.16 (1) be conducted by a certified assessor according to the criteria established in section
599.17 256B.0911, subdivision 3a;

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

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

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

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

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

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

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

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

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

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

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

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

556.13 (c) A pregnant woman eligible for medical assistance under section 256B.055, subdivision
556.14 6, is eligible for CFSS without federal financial participation if the woman: (1) is eligible
556.15 for CFSS under paragraphs (a) and (b); and (2) does not meet institutional level of care, as
556.16 determined under section 256B.0911.

556.17 Sec. 61. Minnesota Statutes 2020, section 256B.85, subdivision 4, is amended to read:

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

556.21 Sec. 62. Minnesota Statutes 2020, section 256B.85, subdivision 5, is amended to read:

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

556.23 (1) be conducted by a certified assessor according to the criteria established in section
556.24 256B.0911, subdivision 3a;

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

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

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

599.29 (c) The lead agency assessor may authorize a temporary authorization for CFSS services
 599.30 to be provided under the agency-provider model. The lead agency assessor may authorize
 599.31 a temporary authorization for CFSS services to be provided under the agency-provider
 600.1 model without using the assessment process described in this subdivision. Authorization
 600.2 for a temporary level of CFSS services under the agency-provider model is limited to the
 600.3 time specified by the commissioner, but shall not exceed 45 days. The level of services
 600.4 authorized under this paragraph shall have no bearing on a future authorization. ~~Participants~~
 600.5 ~~approved for a temporary authorization shall access the consultation service~~ For CFSS
 600.6 services needed beyond the 45-day temporary authorization, the lead agency must conduct
 600.7 an assessment as described in this subdivision and participants must use consultation services
 600.8 to complete their orientation and selection of a service model.

600.9 Sec. 8. Minnesota Statutes 2020, section 256B.85, subdivision 6, is amended to read:

600.10 Subd. 6. **Community first services and supports service delivery plan.** (a) The CFSS
 600.11 service delivery plan must be developed and evaluated through a person-centered planning
 600.12 process by the participant, or the participant's representative or legal representative who
 600.13 may be assisted by a consultation services provider. The CFSS service delivery plan must
 600.14 reflect the services and supports that are important to the participant and for the participant
 600.15 to meet the needs assessed by the certified assessor and identified in the coordinated service
 600.16 and support plan identified in ~~section~~ sections 256B.092, subdivision 1b, and 256S.10. The
 600.17 CFSS service delivery plan must be reviewed by the participant, the consultation services
 600.18 provider, and the agency-provider or FMS provider prior to starting services and at least
 600.19 annually upon reassessment, or when there is a significant change in the participant's
 600.20 condition, or a change in the need for services and supports.

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

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

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

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

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

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

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

557.7 (c) The lead agency assessor may authorize a temporary authorization for CFSS services
 557.8 to be provided under the agency-provider model. The lead agency assessor may authorize
 557.9 a temporary authorization for CFSS services to be provided under the agency-provider
 557.10 model without using the assessment process described in this subdivision. Authorization
 557.11 for a temporary level of CFSS services under the agency-provider model is limited to the
 557.12 time specified by the commissioner, but shall not exceed 45 days. The level of services
 557.13 authorized under this paragraph shall have no bearing on a future authorization. ~~Participants~~
 557.14 ~~approved for a temporary authorization shall access the consultation service~~ For CFSS
 557.15 services needed beyond the 45-day temporary authorization, the lead agency must conduct
 557.16 an assessment as described in this subdivision and participants must use consultation services
 557.17 to complete their orientation and selection of a service model.

557.18 Sec. 63. Minnesota Statutes 2020, section 256B.85, subdivision 6, is amended to read:

557.19 Subd. 6. **Community first services and supports service delivery plan.** (a) The CFSS
 557.20 service delivery plan must be developed and evaluated through a person-centered planning
 557.21 process by the participant, or the participant's representative or legal representative who
 557.22 may be assisted by a consultation services provider. The CFSS service delivery plan must
 557.23 reflect the services and supports that are important to the participant and for the participant
 557.24 to meet the needs assessed by the certified assessor and identified in the coordinated service
 557.25 and support plan identified in ~~section~~ sections 256B.092, subdivision 1b, and 256S.10. The
 557.26 CFSS service delivery plan must be reviewed by the participant, the consultation services
 557.27 provider, and the agency-provider or FMS provider prior to starting services and at least
 557.28 annually upon reassessment, or when there is a significant change in the participant's
 557.29 condition, or a change in the need for services and supports.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

602.1 (f) The CFSS service delivery plan must be approved by the consultation services provider
602.2 for participants without a case manager or care coordinator who is responsible for authorizing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

559.8 (f) The CFSS service delivery plan must be approved by the consultation services provider
559.9 for participants without a case manager or care coordinator who is responsible for authorizing

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

602.5 Sec. 9. Minnesota Statutes 2020, section 256B.85, subdivision 7, is amended to read:

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

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

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

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

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

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

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

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

602.24 (6) services provided by a consultation services provider as defined under subdivision
602.25 17, that is under contract with the department and enrolled as a Minnesota health care
602.26 program provider;

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

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

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

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

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

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

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

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

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

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

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

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

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

560.1 (6) services provided by a consultation services provider as defined under subdivision
560.2 17, that is under contract with the department and enrolled as a Minnesota health care
560.3 program provider;

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

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

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

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

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

603.8 Sec. 10. Minnesota Statutes 2020, section 256B.85, subdivision 8, is amended to read:

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

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

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

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

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

603.22 (3) the presence of Level I behavior.

603.23 (d) The methodology to determine the total service units for CFSS for each home care
603.24 rating is based on the median paid units per day for each home care rating from fiscal year
603.25 2007 data for the PCA program.

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

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

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

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

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

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

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

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

560.16 Sec. 65. Minnesota Statutes 2020, section 256B.85, subdivision 8, is amended to read:

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

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

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

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

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

560.30 (3) the presence of Level I behavior.

561.1 (d) The methodology to determine the total service units for CFSS for each home care
561.2 rating is based on the median paid units per day for each home care rating from fiscal year
561.3 2007 data for the PCA program.

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

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

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

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

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

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

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

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

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

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

604.15 (10) EN home care rating includes ventilator dependency as defined in section 256B.0651,
604.16 subdivision 1, paragraph (g). A person who meets the definition of ventilator-dependent
604.17 and the EN home care rating and utilize a combination of CFSS and home care nursing
604.18 services is limited to a total of 96 service units per day for those services in combination.
604.19 Additional units may be authorized when a person's assessment indicates a need for two
604.20 staff to perform activities. Additional time is limited to 16 service units per day.

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

604.23 (1) 30 additional minutes per day for a dependency in each critical activity of daily
604.24 living;

604.25 (2) 30 additional minutes per day for each complex health-related need; and

604.26 (3) 30 additional minutes per day ~~when the~~ for each behavior under this clause that
604.27 requires assistance at least four times per week ~~for one or more of the following behaviors:~~

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

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

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

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

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

605.5 (2) an adjustment needed for administrative expenses.

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

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

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

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

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

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

561.24 (10) EN home care rating includes ventilator dependency as defined in section 256B.0651,
561.25 subdivision 1, paragraph (g). A person who meets the definition of ventilator-dependent
561.26 and the EN home care rating and utilize a combination of CFSS and home care nursing
561.27 services is limited to a total of 96 service units per day for those services in combination.
561.28 Additional units may be authorized when a person's assessment indicates a need for two
561.29 staff to perform activities. Additional time is limited to 16 service units per day.

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

562.1 (1) 30 additional minutes per day for a dependency in each critical activity of daily
562.2 living;

562.3 (2) 30 additional minutes per day for each complex health-related need; and

562.4 (3) 30 additional minutes per day ~~when the~~ for each behavior under this clause that
562.5 requires assistance at least four times per week ~~for one or more of the following behaviors:~~

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

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

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

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

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

562.13 (2) an adjustment needed for administrative expenses.

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

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

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

605.12 (2) CFSS services in the agency-provider model were required to treat an emergency
 605.13 medical condition that if not immediately treated could cause a participant serious physical
 605.14 or mental disability, continuation of severe pain, or death. The CFSS agency provider must
 605.15 request retroactive authorization from the lead agency no later than five working days after
 605.16 providing the initial emergency service. The CFSS agency provider must be able to
 605.17 substantiate the emergency through documentation such as reports, notes, and admission
 605.18 or discharge histories. A lead agency must follow the authorization process in subdivision
 605.19 5 after the lead agency receives the request for authorization from the agency provider;

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

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

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

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

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

606.8 Sec. 12. Minnesota Statutes 2020, section 256B.85, subdivision 9, is amended to read:

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

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

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

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

562.20 (2) CFSS services in the agency-provider model were required to treat an emergency
 562.21 medical condition that if not immediately treated could cause a participant serious physical
 562.22 or mental disability, continuation of severe pain, or death. The CFSS agency provider must
 562.23 request retroactive authorization from the lead agency no later than five working days after
 562.24 providing the initial emergency service. The CFSS agency provider must be able to
 562.25 substantiate the emergency through documentation such as reports, notes, and admission
 562.26 or discharge histories. A lead agency must follow the authorization process in subdivision
 562.27 5 after the lead agency receives the request for authorization from the agency provider;

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

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

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

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

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

563.18 Sec. 67. Minnesota Statutes 2020, section 256B.85, subdivision 9, is amended to read:

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

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

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

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

606.16 (4) supplant natural unpaid supports that appropriately meet a need in the CFSS service

606.17 delivery plan, are provided voluntarily to the participant, and are selected by the participant

606.18 in lieu of other services and supports;

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

606.20 (6) are available through other funding sources, including; but not limited to; funding

606.21 through title IV-E of the Social Security Act.

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

606.23 (1) those that are not for the direct benefit of the participant, except that services for

606.24 caregivers such as training to improve the ability to provide CFSS are considered to directly

606.25 benefit the participant if chosen by the participant and approved in the support plan;

606.26 (2) any fees incurred by the participant, such as Minnesota health care programs fees

606.27 and co-pays, legal fees, or costs related to advocate agencies;

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

606.29 (4) room and board costs for the participant;

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

607.1 (6) special education and related services provided under the Individuals with Disabilities

607.2 Education Act and vocational rehabilitation services provided under the Rehabilitation Act

607.3 of 1973;

607.4 (7) assistive technology devices and assistive technology services other than those for

607.5 back-up systems or mechanisms to ensure continuity of service and supports listed in

607.6 subdivision 7;

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

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

607.9 (10) expenses for travel, lodging, or meals related to training the participant or the

607.10 participant's representative or legal representative;

607.11 (11) experimental treatments;

607.12 (12) any service or good covered by other state plan services, including prescription and

607.13 over-the-counter medications, compounds, and solutions and related fees, including premiums

607.14 and co-payments;

607.15 (13) membership dues or costs, except when the service is necessary and appropriate to

607.16 treat a health condition or to improve or maintain the adult participant's health condition.

607.17 The condition must be identified in the participant's CFSS service delivery plan and

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

563.26 (4) supplant natural unpaid supports that appropriately meet a need in the CFSS service

563.27 delivery plan, are provided voluntarily to the participant, and are selected by the participant

563.28 in lieu of other services and supports;

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

563.30 (6) are available through other funding sources, including; but not limited to; funding

563.31 through title IV-E of the Social Security Act.

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

564.2 (1) those that are not for the direct benefit of the participant, except that services for

564.3 caregivers such as training to improve the ability to provide CFSS are considered to directly

564.4 benefit the participant if chosen by the participant and approved in the support plan;

564.5 (2) any fees incurred by the participant, such as Minnesota health care programs fees

564.6 and co-pays, legal fees, or costs related to advocate agencies;

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

564.8 (4) room and board costs for the participant;

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

564.10 (6) special education and related services provided under the Individuals with Disabilities

564.11 Education Act and vocational rehabilitation services provided under the Rehabilitation Act

564.12 of 1973;

564.13 (7) assistive technology devices and assistive technology services other than those for

564.14 back-up systems or mechanisms to ensure continuity of service and supports listed in

564.15 subdivision 7;

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

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

564.18 (10) expenses for travel, lodging, or meals related to training the participant or the

564.19 participant's representative or legal representative;

564.20 (11) experimental treatments;

564.21 (12) any service or good covered by other state plan services, including prescription and

564.22 over-the-counter medications, compounds, and solutions and related fees, including premiums

564.23 and co-payments;

564.24 (13) membership dues or costs, except when the service is necessary and appropriate to

564.25 treat a health condition or to improve or maintain the adult participant's health condition.

564.26 The condition must be identified in the participant's CFSS service delivery plan and

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

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

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

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

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

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

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

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

607.30 (21) sterile procedures;

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

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

608.2 (24) home maintenance or chore services;

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

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

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

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

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

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

608.12 (31) services provided by ~~the residential or program~~ a foster care license holder in a
608.13 ~~residence for more than four participants.~~ residence for more than four participants, except when the home of the person receiving
608.14 services is the licensed foster care provider's primary residence;

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

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

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

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

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

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

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

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

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

565.8 (21) sterile procedures;

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

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

565.11 (24) home maintenance or chore services;

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

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

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

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

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

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

565.21 (31) services provided by ~~the residential or program~~ a foster care license holder in a
565.22 ~~residence for more than four participants.~~ residence for more than four participants, except when the home of the person receiving
565.23 services is the licensed foster care provider's primary residence;

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

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

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

608.25 (35) instrumental activities of daily living for children younger than 18 years of age,
 608.26 except when immediate attention is needed for health or hygiene reasons integral to an
 608.27 assessed need for assistance with activities of daily living, health-related procedures, and
 608.28 tasks or behaviors; or

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

609.1 Sec. 13. Minnesota Statutes 2020, section 256B.85, subdivision 10, is amended to read:

609.2 Subd. 10. **Agency-provider and FMS provider qualifications and duties.** (a)
 609.3 Agency-providers identified in subdivision 11 and FMS providers identified in subdivision
 609.4 13a shall:

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

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

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

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

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

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

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

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

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

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

566.5 (35) instrumental activities of daily living for children younger than 18 years of age,
 566.6 except when immediate attention is needed for health or hygiene reasons integral to an
 566.7 assessed need for assistance with activities of daily living, health-related procedures, and
 566.8 tasks or behaviors; or

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

566.11 Sec. 68. Minnesota Statutes 2020, section 256B.85, subdivision 10, is amended to read:

566.12 Subd. 10. **Agency-provider and FMS provider qualifications and duties.** (a)
 566.13 Agency-providers identified in subdivision 11 and FMS providers identified in subdivision
 566.14 13a shall:

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

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

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

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

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

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

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

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

609.24 (9) have an office located in Minnesota.

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

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

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

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

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

610.1 (5) enter into a written agreement with the participant, participant's representative, or
610.2 legal representative that assigns roles and responsibilities to be performed before services,
610.3 supports, or goods are provided and that meets the requirements of subdivisions 20a, 20b,
610.4 and 20c for agency-providers;

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

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

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

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

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

610.14 Sec. 14. Minnesota Statutes 2020, section 256B.85, subdivision 11, is amended to read:

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

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

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

567.3 (9) have an office located in Minnesota.

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

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

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

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

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

567.11 (5) enter into a written agreement with the participant, participant's representative, or
567.12 legal representative that assigns roles and responsibilities to be performed before services,
567.13 supports, or goods are provided and that meets the requirements of subdivisions 20a, 20b,
567.14 and 20c for agency-providers;

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

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

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

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

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

567.24 Sec. 69. Minnesota Statutes 2020, section 256B.85, subdivision 11, is amended to read:

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

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

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

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

610.30 (e) The agency-provider must use a minimum of 72.5 percent of the revenue generated
610.31 by the medical assistance payment for CFSS for support worker wages and benefits, except
610.32 all of the revenue generated by a medical assistance rate increase due to a collective
611.1 bargaining agreement under section 179A.54 must be used for support worker wages and
611.2 benefits. The agency-provider must document how this requirement is being met. The
611.3 revenue generated by the worker training and development services and the reasonable costs
611.4 associated with the worker training and development services must not be used in making
611.5 this calculation.

611.6 (f) The agency-provider model must be used by ~~individuals~~ participants who are restricted
611.7 by the Minnesota restricted recipient program under Minnesota Rules, parts 9505.2160 to
611.8 9505.2245.

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

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

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

611.15 Sec. 15. Minnesota Statutes 2020, section 256B.85, subdivision 11b, is amended to read:

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

611.23 (1) any support worker beginning to provide services for a participant; or
611.24 (2) any support worker beginning to provide shared services.

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

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

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

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

568.10 (e) The agency-provider must use a minimum of 72.5 percent of the revenue generated
568.11 by the medical assistance payment for CFSS for support worker wages and benefits, except
568.12 all of the revenue generated by a medical assistance rate increase due to a collective
568.13 bargaining agreement under section 179A.54 must be used for support worker wages and
568.14 benefits. The agency-provider must document how this requirement is being met. The
568.15 revenue generated by the worker training and development services and the reasonable costs
568.16 associated with the worker training and development services must not be used in making
568.17 this calculation.

568.18 (f) The agency-provider model must be used by ~~individuals~~ participants who are restricted
568.19 by the Minnesota restricted recipient program under Minnesota Rules, parts 9505.2160 to
568.20 9505.2245.

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

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

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

568.27 Sec. 70. Minnesota Statutes 2020, section 256B.85, subdivision 11b, is amended to read:

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

569.3 (1) any support worker beginning to provide services for a participant; or
569.4 (2) any support worker beginning to provide shared services.

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

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

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

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

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

612.4 ~~(4)~~ (5) periodic performance reviews completed by the agency-provider at least annually,
 612.5 including any evaluations required under subdivision 11a, paragraph (a). If a support worker
 612.6 is a minor, all evaluations of worker competency must be completed in person and in a
 612.7 setting where the participant is using CFSS.

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

612.11 (1) the support worker begins providing services;
 612.12 (2) the support worker begins providing shared services;

612.13 ~~(2)~~ (3) there is any change in condition or a modification to the CFSS service delivery
 612.14 plan; or

612.15 ~~(3)~~ (4) a performance review indicates that additional training is needed.

612.16 Sec. 16. Minnesota Statutes 2020, section 256B.85, subdivision 12, is amended to read:

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

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

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

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

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

613.1 (5) proof of liability insurance;

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

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

569.15 ~~(4)~~ (5) periodic performance reviews completed by the agency-provider at least annually,
 569.16 including any evaluations required under subdivision 11a, paragraph (a). If a support worker
 569.17 is a minor, all evaluations of worker competency must be completed in person and in a
 569.18 setting where the participant is using CFSS.

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

569.22 (1) the support worker begins providing services;
 569.23 (2) the support worker begins providing shared services;

569.24 ~~(2)~~ (3) there is any change in condition or a modification to the CFSS service delivery
 569.25 plan; or

569.26 ~~(3)~~ (4) a performance review indicates that additional training is needed.

569.27 Sec. 71. Minnesota Statutes 2020, section 256B.85, subdivision 12, is amended to read:

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

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

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

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

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

570.12 (5) proof of liability insurance;

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

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

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

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

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

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

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

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

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

613.22 (13) documentation that the agency-provider will use at least the following percentages
 613.23 of revenue generated from the medical assistance rate paid for CFSS services for CFSS
 613.24 support worker wages and benefits: 72.5 percent of revenue from CFSS providers, except
 613.25 100 percent of the revenue generated by a medical assistance rate increase due to a collective
 613.26 bargaining agreement under section 179A.54 must be used for support worker wages and
 613.27 benefits. The revenue generated by the worker training and development services and the
 613.28 reasonable costs associated with the worker training and development services shall not be
 613.29 used in making this calculation; and

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

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

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

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

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

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

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

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

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

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

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

571.1 (13) documentation that the agency-provider will use at least the following percentages
 571.2 of revenue generated from the medical assistance rate paid for CFSS services for CFSS
 571.3 support worker wages and benefits: 72.5 percent of revenue from CFSS providers, except
 571.4 100 percent of the revenue generated by a medical assistance rate increase due to a collective
 571.5 bargaining agreement under section 179A.54 must be used for support worker wages and
 571.6 benefits. The revenue generated by the worker training and development services and the
 571.7 reasonable costs associated with the worker training and development services shall not be
 571.8 used in making this calculation; and

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

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

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

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

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

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

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

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

614.24 (d) Agency-providers shall submit all required documentation in this section within 30
 614.25 days of notification from the commissioner. If an agency-provider fails to submit all the
 614.26 required documentation, the commissioner may take action under subdivision 23a.

614.27 Sec. 17. Minnesota Statutes 2020, section 256B.85, subdivision 12b, is amended to read:

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

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

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

615.6 (3) an emergency or a significant change in the participant's condition occurs within a
 615.7 24-hour period that results in the participant's service needs exceeding the participant's
 615.8 identified needs in the current CFSS service delivery plan so that the agency-provider cannot
 615.9 safely meet the participant's needs.

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

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

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

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

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

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

572.4 (d) Agency-providers shall submit all required documentation in this section within 30
 572.5 days of notification from the commissioner. If an agency-provider fails to submit all the
 572.6 required documentation, the commissioner may take action under subdivision 23a.

572.7 Sec. 72. Minnesota Statutes 2020, section 256B.85, subdivision 12b, is amended to read:

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

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

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

572.17 (3) an emergency or a significant change in the participant's condition occurs within a
 572.18 24-hour period that results in the participant's service needs exceeding the participant's
 572.19 identified needs in the current CFSS service delivery plan so that the agency-provider cannot
 572.20 safely meet the participant's needs.

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

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

615.16 Sec. 18. Minnesota Statutes 2020, section 256B.85, subdivision 13, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

616.16 Sec. 19. Minnesota Statutes 2020, section 256B.85, subdivision 13a, is amended to read:

616.17 Subd. 13a. **Financial management services.** (a) Services provided by an FMS provider
616.18 include but are not limited to: filing and payment of federal and state payroll taxes on behalf
616.19 of the participant; initiating and complying with background study requirements under
616.20 chapter 245C and maintaining documentation of background study requests and results;
616.21 billing for approved CFSS services with authorized funds; monitoring expenditures;
616.22 accounting for and disbursing CFSS funds; providing assistance in obtaining and filing for
616.23 liability, workers' compensation, and unemployment coverage; and providing participant
616.24 instruction and technical assistance to the participant in fulfilling employer-related
616.25 requirements in accordance with section 3504 of the Internal Revenue Code and related
616.26 regulations and interpretations, including Code of Federal Regulations, title 26, section
616.27 31.3504-1.

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

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

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

617.1 (2) data recording and reporting of participant spending;

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

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

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

617.10 (e) The FMS provider shall:

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

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

617.16 (3) be knowledgeable of state and federal employment regulations, including those under
617.17 the Fair Labor Standards Act of 1938, and comply with the requirements under section 3504
617.18 of the Internal Revenue Code and related regulations and interpretations, including Code

573.25 Sec. 74. Minnesota Statutes 2020, section 256B.85, subdivision 13a, is amended to read:

573.26 Subd. 13a. **Financial management services.** (a) Services provided by an FMS provider
573.27 include but are not limited to: filing and payment of federal and state payroll taxes on behalf
573.28 of the participant; initiating and complying with background study requirements under
573.29 chapter 245C and maintaining documentation of background study requests and results;
573.30 billing for approved CFSS services with authorized funds; monitoring expenditures;
573.31 accounting for and disbursing CFSS funds; providing assistance in obtaining and filing for
573.32 liability, workers' compensation, and unemployment coverage; and providing participant
574.1 instruction and technical assistance to the participant in fulfilling employer-related
574.2 requirements in accordance with section 3504 of the Internal Revenue Code and related
574.3 regulations and interpretations, including Code of Federal Regulations, title 26, section
574.4 31.3504-1.

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

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

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

574.11 (2) data recording and reporting of participant spending;

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

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

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

574.20 (e) The FMS provider shall:

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

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

574.26 (3) be knowledgeable of state and federal employment regulations, including those under
574.27 the Fair Labor Standards Act of 1938, and comply with the requirements under section 3504
574.28 of the Internal Revenue Code and related regulations and interpretations, including Code

617.19 of Federal Regulations, title 26, section 31.3504-1, regarding agency employer tax liability
617.20 for vendor fiscal/employer agent, and any requirements necessary to process employer and
617.21 employee deductions, provide appropriate and timely submission of employer tax liabilities,
617.22 and maintain documentation to support medical assistance claims;

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

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

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

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

618.6 (f) The commissioner ~~of human services~~ shall:

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

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

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

618.12 Sec. 20. Minnesota Statutes 2020, section 256B.85, is amended by adding a subdivision
618.13 to read:

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

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

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

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

574.29 of Federal Regulations, title 26, section 31.3504-1, regarding agency employer tax liability
574.30 for vendor fiscal/employer agent, and any requirements necessary to process employer and
574.31 employee deductions, provide appropriate and timely submission of employer tax liabilities,
574.32 and maintain documentation to support medical assistance claims;

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

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

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

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

575.17 (f) The commissioner ~~of human services~~ shall:

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

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

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

575.23 Sec. 75. Minnesota Statutes 2020, section 256B.85, is amended by adding a subdivision
575.24 to read:

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

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

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

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

618.21 (b) A participant's representative must:
618.22 (1) be at least 18 years of age;
618.23 (2) actively participate in planning and directing CFSS services;
618.24 (3) have sufficient knowledge of the participant's circumstances to use CFSS services
618.25 consistent with the participant's health and safety needs identified in the participant's service
618.26 delivery plan;
618.27 (4) not have a financial interest in the provision of any services included in the
618.28 participant's CFSS service delivery plan; and
618.29 (5) be capable of providing the support necessary to assist the participant in the use of
618.30 CFSS services.
619.1 (c) A participant's representative must not be the:
619.2 (1) support worker;
619.3 (2) worker training and development service provider;
619.4 (3) agency-provider staff, unless related to the participant by blood, marriage, or adoption;
619.5 (4) consultation service provider, unless related to the participant by blood, marriage,
619.6 or adoption;
619.7 (5) FMS staff, unless related to the participant by blood, marriage, or adoption;
619.8 (6) FMS owner or manager; or
619.9 (7) lead agency staff acting as part of employment.
619.10 (d) A licensed family foster parent who lives with the participant may be the participant's
619.11 representative if the family foster parent meets the other participant's representative
619.12 requirements.
619.13 (e) There may be two persons designated as the participant's representative, including
619.14 instances of divided households and court-ordered custodies. Each person named as the
619.15 participant's representative must meet the program criteria and responsibilities.
619.16 (f) The participant or the participant's legal representative shall appoint a participant's
619.17 representative. The participant's representative must be identified at the time of assessment
619.18 and listed on the participant's service agreement and CFSS service delivery plan.
619.19 (g) A participant's representative must enter into a written agreement with an
619.20 agency-provider or FMS on a form determined by the commissioner and maintained in the
619.21 participant's file, to:

576.1 (b) A participant's representative must:
576.2 (1) be at least 18 years of age;
576.3 (2) actively participate in planning and directing CFSS services;
576.4 (3) have sufficient knowledge of the participant's circumstances to use CFSS services
576.5 consistent with the participant's health and safety needs identified in the participant's service
576.6 delivery plan;
576.7 (4) not have a financial interest in the provision of any services included in the
576.8 participant's CFSS service delivery plan; and
576.9 (5) be capable of providing the support necessary to assist the participant in the use of
576.10 CFSS services.
576.11 (c) A participant's representative must not be the:
576.12 (1) support worker;
576.13 (2) worker training and development service provider;
576.14 (3) agency-provider staff, unless related to the participant by blood, marriage, or adoption;
576.15 (4) consultation service provider, unless related to the participant by blood, marriage,
576.16 or adoption;
576.17 (5) FMS staff, unless related to the participant by blood, marriage, or adoption;
576.18 (6) FMS owner or manager; or
576.19 (7) lead agency staff acting as part of employment.
576.20 (d) A licensed family foster parent who lives with the participant may be the participant's
576.21 representative if the family foster parent meets the other participant's representative
576.22 requirements.
576.23 (e) There may be two persons designated as the participant's representative, including
576.24 instances of divided households and court-ordered custodies. Each person named as the
576.25 participant's representative must meet the program criteria and responsibilities.
576.26 (f) The participant or the participant's legal representative shall appoint a participant's
576.27 representative. The participant's representative must be identified at the time of assessment
576.28 and listed on the participant's service agreement and CFSS service delivery plan.
577.1 (g) A participant's representative must enter into a written agreement with an
577.2 agency-provider or FMS on a form determined by the commissioner and maintained in the
577.3 participant's file, to:

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

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

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

619.28 (4) review and sign vendor paperwork to verify receipt of goods; and

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

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

620.4 (1) ensure that the delegate serving as the participant's representative satisfies the
 620.5 requirements of the participant's representative;

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

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

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

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

620.13 (1) the participant revokes the designation;

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

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

620.17 (4) the participant's representative is disqualified.

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

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

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

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

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

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

577.10 (4) review and sign vendor paperwork to verify receipt of goods; and

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

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

577.16 (1) ensure that the delegate serving as the participant's representative satisfies the
 577.17 requirements of the participant's representative;

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

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

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

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

577.25 (1) the participant revokes the designation;

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

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

577.29 (4) the participant's representative is disqualified.

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

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

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

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

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

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

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

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

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

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

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

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

621.15 (3) the participant's full name;

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

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

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

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

621.24 (8) any shared care provided, if applicable;

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

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

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

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

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

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

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

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

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

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

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

578.26 (3) the participant's full name;

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

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

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

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

579.5 (8) any shared care provided, if applicable;

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

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

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

622.2 Subd. 17a. **Consultation services provider qualifications and**

622.3 **requirements.** Consultation services providers must meet the following qualifications and

622.4 requirements:

622.5 (1) meet the requirements under subdivision 10, paragraph (a), excluding clauses (4)

622.6 and (5);

622.7 (2) are under contract with the department;

622.8 (3) are not the FMS provider, the lead agency, or the CFSS or home and community-based

622.9 services waiver vendor or agency-provider to the participant;

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

622.11 (5) have proof of surety bond coverage. Upon new enrollment, or if the consultation

622.12 service provider's Medicaid revenue in the previous calendar year is less than or equal to

622.13 \$300,000, the consultation service provider must purchase a surety bond of \$50,000. If the

622.14 agency-provider's Medicaid revenue in the previous calendar year is greater than \$300,000,

622.15 the consultation service provider must purchase a surety bond of \$100,000. The surety bond

622.16 must be in a form approved by the commissioner, must be renewed annually, and must

622.17 allow for recovery of costs and fees in pursuing a claim on the bond;

622.18 ~~(5)~~ (6) employ lead professional staff with a minimum of ~~three~~ two years of experience

622.19 in providing services such as support planning, support broker, case management or care

622.20 coordination, or consultation services and consumer education to participants using a

622.21 self-directed program using FMS under medical assistance;

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

622.23 ~~(6)~~ (8) comply with medical assistance provider requirements;

622.24 ~~(7)~~ (9) understand the CFSS program and its policies;

622.25 ~~(8)~~ (10) are knowledgeable about self-directed principles and the application of the

622.26 person-centered planning process;

622.27 ~~(9)~~ (11) have general knowledge of the FMS provider duties and the vendor

622.28 fiscal/employer agent model, including all applicable federal, state, and local laws and

622.29 regulations regarding tax, labor, employment, and liability and workers' compensation

622.30 coverage for household workers; and

622.31 ~~(10)~~ (12) have all employees, including lead professional staff, staff in management and

622.32 supervisory positions, and owners of the agency who are active in the day-to-day management

623.1 and operations of the agency, complete training as specified in the contract with the

623.2 department.

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

579.11 Subd. 17a. **Consultation services provider qualifications and**

579.12 **requirements.** Consultation services providers must meet the following qualifications and

579.13 requirements:

579.14 (1) meet the requirements under subdivision 10, paragraph (a), excluding clauses (4)

579.15 and (5);

579.16 (2) are under contract with the department;

579.17 (3) are not the FMS provider, the lead agency, or the CFSS or home and community-based

579.18 services waiver vendor or agency-provider to the participant;

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

579.20 (5) have proof of surety bond coverage. Upon new enrollment, or if the consultation

579.21 service provider's Medicaid revenue in the previous calendar year is less than or equal to

579.22 \$300,000, the consultation service provider must purchase a surety bond of \$50,000. If the

579.23 agency-provider's Medicaid revenue in the previous calendar year is greater than \$300,000,

579.24 the consultation service provider must purchase a surety bond of \$100,000. The surety bond

579.25 must be in a form approved by the commissioner, must be renewed annually, and must

579.26 allow for recovery of costs and fees in pursuing a claim on the bond;

579.27 ~~(5)~~ (6) employ lead professional staff with a minimum of ~~three~~ two years of experience

579.28 in providing services such as support planning, support broker, case management or care

579.29 coordination, or consultation services and consumer education to participants using a

579.30 self-directed program using FMS under medical assistance;

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

580.1 ~~(6)~~ (8) comply with medical assistance provider requirements;

580.2 ~~(7)~~ (9) understand the CFSS program and its policies;

580.3 ~~(8)~~ (10) are knowledgeable about self-directed principles and the application of the

580.4 person-centered planning process;

580.5 ~~(9)~~ (11) have general knowledge of the FMS provider duties and the vendor

580.6 fiscal/employer agent model, including all applicable federal, state, and local laws and

580.7 regulations regarding tax, labor, employment, and liability and workers' compensation

580.8 coverage for household workers; and

580.9 ~~(10)~~ (12) have all employees, including lead professional staff, staff in management and

580.10 supervisory positions, and owners of the agency who are active in the day-to-day management

580.11 and operations of the agency, complete training as specified in the contract with the

580.12 department.

623.3 Sec. 23. Minnesota Statutes 2020, section 256B.85, subdivision 18a, is amended to read:

623.4 Subd. 18a. **Worker training and development services.** (a) The commissioner shall

623.5 develop the scope of tasks and functions, service standards, and service limits for worker

623.6 training and development services.

623.7 (b) Worker training and development costs are in addition to the participant's assessed

623.8 service units or service budget. Services provided according to this subdivision must:

623.9 (1) help support workers obtain and expand the skills and knowledge necessary to ensure

623.10 competency in providing quality services as needed and defined in the participant's CFSS

623.11 service delivery plan and as required under subdivisions 11b and 14;

623.12 (2) be provided or arranged for by the agency-provider under subdivision 11, or purchased

623.13 by the participant employer under the budget model as identified in subdivision 13; ~~and~~

623.14 (3) be delivered by an individual competent to perform, teach, or assign the tasks,

623.15 including health-related tasks, identified in the plan through education, training, and work

623.16 experience relevant to the person's assessed needs; and

623.17 ~~(3)~~ (4) be described in the participant's CFSS service delivery plan and documented in

623.18 the participant's file.

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

623.20 (1) support worker training on the participant's individual assessed needs and condition,

623.21 provided individually or in a group setting by a skilled and knowledgeable trainer beyond

623.22 any training the participant or participant's representative provides;

623.23 (2) tuition for professional classes and workshops for the participant's support workers

623.24 that relate to the participant's assessed needs and condition;

623.25 (3) direct observation, monitoring, coaching, and documentation of support worker job

623.26 skills and tasks, beyond any training the participant or participant's representative provides,

623.27 including supervision of health-related tasks or behavioral supports that is conducted by an

623.28 appropriate professional based on the participant's assessed needs. These services must be

623.29 provided at the start of services or the start of a new support worker except as provided in

623.30 paragraph (d) and must be specified in the participant's CFSS service delivery plan; and

623.31 (4) the activities to evaluate CFSS services and ensure support worker competency

623.32 described in subdivisions 11a and 11b.

624.1 (d) The services in paragraph (c), clause (3), are not required to be provided for a new

624.2 support worker providing services for a participant due to staffing failures, unless the support

624.3 worker is expected to provide ongoing backup staffing coverage.

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

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

580.13 Sec. 78. Minnesota Statutes 2020, section 256B.85, subdivision 18a, is amended to read:

580.14 Subd. 18a. **Worker training and development services.** (a) The commissioner shall

580.15 develop the scope of tasks and functions, service standards, and service limits for worker

580.16 training and development services.

580.17 (b) Worker training and development costs are in addition to the participant's assessed

580.18 service units or service budget. Services provided according to this subdivision must:

580.19 (1) help support workers obtain and expand the skills and knowledge necessary to ensure

580.20 competency in providing quality services as needed and defined in the participant's CFSS

580.21 service delivery plan and as required under subdivisions 11b and 14;

580.22 (2) be provided or arranged for by the agency-provider under subdivision 11, or purchased

580.23 by the participant employer under the budget model as identified in subdivision 13; ~~and~~

580.24 (3) be delivered by an individual competent to perform, teach, or assign the tasks,

580.25 including health-related tasks, identified in the plan through education, training, and work

580.26 experience relevant to the person's assessed needs; and

580.27 ~~(3)~~ (4) be described in the participant's CFSS service delivery plan and documented in

580.28 the participant's file.

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

581.1 (1) support worker training on the participant's individual assessed needs and condition,

581.2 provided individually or in a group setting by a skilled and knowledgeable trainer beyond

581.3 any training the participant or participant's representative provides;

581.4 (2) tuition for professional classes and workshops for the participant's support workers

581.5 that relate to the participant's assessed needs and condition;

581.6 (3) direct observation, monitoring, coaching, and documentation of support worker job

581.7 skills and tasks, beyond any training the participant or participant's representative provides,

581.8 including supervision of health-related tasks or behavioral supports that is conducted by an

581.9 appropriate professional based on the participant's assessed needs. These services must be

581.10 provided at the start of services or the start of a new support worker except as provided in

581.11 paragraph (d) and must be specified in the participant's CFSS service delivery plan; and

581.12 (4) the activities to evaluate CFSS services and ensure support worker competency

581.13 described in subdivisions 11a and 11b.

581.14 (d) The services in paragraph (c), clause (3), are not required to be provided for a new

581.15 support worker providing services for a participant due to staffing failures, unless the support

581.16 worker is expected to provide ongoing backup staffing coverage.

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

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

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

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

624.8 (4) training or supervision provided by the participant, the participant's support worker,

624.9 or the participant's informal supports, including the participant's representative; or

624.10 (5) services in excess of ~~96 units~~ the rate set by the commissioner per annual service

624.11 agreement, unless approved by the department.

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

624.13 Subd. 20b. **Service-related rights under an agency-provider.** A participant receiving

624.14 CFSS from an agency-provider has service-related rights to:

624.15 (1) participate in and approve the initial development and ongoing modification and

624.16 evaluation of CFSS services provided to the participant;

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

624.18 terminating services;

624.19 (3) before services are initiated, be told the limits to the services available from the

624.20 agency-provider, including the agency-provider's knowledge, skill, and ability to meet the

624.21 participant's needs identified in the CFSS service delivery plan;

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

624.23 (5) before services are initiated, be told what the agency-provider charges for the services;

624.24 (6) before services are initiated, be told to what extent payment may be expected from

624.25 health insurance, public programs, or other sources, if known; and what charges the

624.26 participant may be responsible for paying;

624.27 (7) receive services from an individual who is competent and trained, who has

624.28 professional certification or licensure, as required, and who meets additional qualifications

624.29 identified in the participant's CFSS service delivery plan;

625.1 (8) have the participant's preferences for support workers identified and documented,

625.2 and have those preferences met when possible; and

625.3 (9) before services are initiated, be told the choices that are available from the

625.4 agency-provider for meeting the participant's assessed needs identified in the CFSS service

625.5 delivery plan, including but not limited to which support worker staff will be providing

625.6 services ~~and~~ the proposed frequency and schedule of visits, and any agreements for shared

625.7 services.

625.8 Sec. 25. Minnesota Statutes 2020, section 256B.85, subdivision 23, is amended to read:

625.9 Subd. 23. **Commissioner's access.** (a) When the commissioner is investigating a possible

625.10 overpayment of Medicaid funds, the commissioner must be given immediate access without

581.19 (2) payment for preparation or development time for the trainer or presenter;

581.20 (3) payment of the support worker's salary or compensation during the training;

581.21 (4) training or supervision provided by the participant, the participant's support worker,

581.22 or the participant's informal supports, including the participant's representative; or

581.23 (5) services in excess of ~~96 units~~ the limit set by the commissioner per annual service

581.24 agreement, unless approved by the department.

581.25 Sec. 79. Minnesota Statutes 2020, section 256B.85, subdivision 20b, is amended to read:

581.26 Subd. 20b. **Service-related rights under an agency-provider.** A participant receiving

581.27 CFSS from an agency-provider has service-related rights to:

581.28 (1) participate in and approve the initial development and ongoing modification and

581.29 evaluation of CFSS services provided to the participant;

581.30 (2) refuse or terminate services and be informed of the consequences of refusing or

581.31 terminating services;

582.1 (3) before services are initiated, be told the limits to the services available from the

582.2 agency-provider, including the agency-provider's knowledge, skill, and ability to meet the

582.3 participant's needs identified in the CFSS service delivery plan;

582.4 (4) a coordinated transfer of services when there will be a change in the agency-provider;

582.5 (5) before services are initiated, be told what the agency-provider charges for the services;

582.6 (6) before services are initiated, be told to what extent payment may be expected from

582.7 health insurance, public programs, or other sources, if known; and what charges the

582.8 participant may be responsible for paying;

582.9 (7) receive services from an individual who is competent and trained, who has

582.10 professional certification or licensure, as required, and who meets additional qualifications

582.11 identified in the participant's CFSS service delivery plan;

582.12 (8) have the participant's preferences for support workers identified and documented,

582.13 and have those preferences met when possible; and

582.14 (9) before services are initiated, be told the choices that are available from the

582.15 agency-provider for meeting the participant's assessed needs identified in the CFSS service

582.16 delivery plan, including but not limited to which support worker staff will be providing

582.17 services ~~and~~ the proposed frequency and schedule of visits, and any agreements for shared

582.18 services.

582.19 Sec. 80. Minnesota Statutes 2020, section 256B.85, subdivision 23, is amended to read:

582.20 Subd. 23. **Commissioner's access.** (a) When the commissioner is investigating a possible

582.21 overpayment of Medicaid funds, the commissioner must be given immediate access without

625.11 prior notice to the agency-provider, consultation services provider, or FMS provider's office
 625.12 during regular business hours and to documentation and records related to services provided
 625.13 and submission of claims for services provided. ~~Denying the commissioner access to records~~
 625.14 ~~is cause for immediate suspension of payment and terminating.~~ If the agency-provider's
 625.15 ~~enrollment or agency-provider, FMS provider's enrollment~~ provider, or consultation services
 625.16 provider denies the commissioner access to records, the provider's payment may be
 625.17 ~~immediately suspended or the provider's enrollment may be terminated~~ according to section
 625.18 256B.064 ~~or terminating the consultation services provider contract.~~

625.19 (b) The commissioner has the authority to request proof of compliance with laws, rules,
 625.20 and policies from agency-providers, consultation services providers, FMS providers, and
 625.21 participants.

625.22 (c) When relevant to an investigation conducted by the commissioner, the commissioner
 625.23 must be given access to the business office, documents, and records of the agency-provider,
 625.24 consultation services provider, or FMS provider, including records maintained in electronic
 625.25 format; participants served by the program; and staff during regular business hours. The
 625.26 commissioner must be given access without prior notice and as often as the commissioner
 625.27 considers necessary if the commissioner is investigating an alleged violation of applicable
 625.28 laws or rules. The commissioner may request and shall receive assistance from lead agencies
 625.29 and other state, county, and municipal agencies and departments. The commissioner's access
 625.30 includes being allowed to photocopy, photograph, and make audio and video recordings at
 625.31 the commissioner's expense.

626.1 Sec. 26. Minnesota Statutes 2020, section 256B.85, subdivision 23a, is amended to read:

626.2 Subd. 23a. **Sanctions; information for participants upon termination of services.** (a)
 626.3 The commissioner may withhold payment from the provider or suspend or terminate the
 626.4 provider enrollment number if the provider fails to comply fully with applicable laws or
 626.5 rules. The provider has the right to appeal the decision of the commissioner under section
 626.6 256B.064.

626.7 (b) Notwithstanding subdivision 13, paragraph (c), if a participant employer fails to
 626.8 comply fully with applicable laws or rules, the commissioner may disenroll the participant
 626.9 from the budget model. A participant may appeal in writing to the department under section
 626.10 256.045, subdivision 3, to contest the department's decision to disenroll the participant from
 626.11 the budget model.

626.12 (c) Agency-providers of CFSS services or FMS providers must provide each participant
 626.13 with a copy of participant protections in subdivision 20c at least 30 days prior to terminating
 626.14 services to a participant, if the termination results from sanctions under this subdivision or
 626.15 section 256B.064, such as a payment withhold or a suspension or termination of the provider
 626.16 enrollment number. If a CFSS agency-provider ~~or~~, FMS provider, ~~or~~ consultation services
 626.17 provider determines it is unable to continue providing services to a participant because of
 626.18 an action under this subdivision or section 256B.064, the agency-provider ~~or~~, FMS provider,
 626.19 ~~or~~ consultation services provider must notify the participant, the participant's representative,

582.22 prior notice to the agency-provider, consultation services provider, or FMS provider's office
 582.23 during regular business hours and to documentation and records related to services provided
 582.24 and submission of claims for services provided. ~~Denying the commissioner access to records~~
 582.25 ~~is cause for immediate suspension of payment and terminating.~~ If the agency-provider's
 582.26 ~~enrollment or agency-provider, FMS provider's enrollment~~ provider, or consultation services
 582.27 provider denies the commissioner access to records, the provider's payment may be
 582.28 ~~immediately suspended or the provider's enrollment may be terminated~~ according to section
 582.29 256B.064 ~~or terminating the consultation services provider contract.~~

582.30 (b) The commissioner has the authority to request proof of compliance with laws, rules,
 582.31 and policies from agency-providers, consultation services providers, FMS providers, and
 582.32 participants.

583.1 (c) When relevant to an investigation conducted by the commissioner, the commissioner
 583.2 must be given access to the business office, documents, and records of the agency-provider,
 583.3 consultation services provider, or FMS provider, including records maintained in electronic
 583.4 format; participants served by the program; and staff during regular business hours. The
 583.5 commissioner must be given access without prior notice and as often as the commissioner
 583.6 considers necessary if the commissioner is investigating an alleged violation of applicable
 583.7 laws or rules. The commissioner may request and shall receive assistance from lead agencies
 583.8 and other state, county, and municipal agencies and departments. The commissioner's access
 583.9 includes being allowed to photocopy, photograph, and make audio and video recordings at
 583.10 the commissioner's expense.

583.11 Sec. 81. Minnesota Statutes 2020, section 256B.85, subdivision 23a, is amended to read:

583.12 Subd. 23a. **Sanctions; information for participants upon termination of services.** (a)
 583.13 The commissioner may withhold payment from the provider or suspend or terminate the
 583.14 provider enrollment number if the provider fails to comply fully with applicable laws or
 583.15 rules. The provider has the right to appeal the decision of the commissioner under section
 583.16 256B.064.

583.17 (b) Notwithstanding subdivision 13, paragraph (c), if a participant employer fails to
 583.18 comply fully with applicable laws or rules, the commissioner may disenroll the participant
 583.19 from the budget model. A participant may appeal in writing to the department under section
 583.20 256.045, subdivision 3, to contest the department's decision to disenroll the participant from
 583.21 the budget model.

583.22 (c) Agency-providers of CFSS services or FMS providers must provide each participant
 583.23 with a copy of participant protections in subdivision 20c at least 30 days prior to terminating
 583.24 services to a participant, if the termination results from sanctions under this subdivision or
 583.25 section 256B.064, such as a payment withhold or a suspension or termination of the provider
 583.26 enrollment number. If a CFSS agency-provider ~~or~~, FMS provider, ~~or~~ consultation services
 583.27 provider determines it is unable to continue providing services to a participant because of
 583.28 an action under this subdivision or section 256B.064, the agency-provider ~~or~~, FMS provider,
 583.29 ~~or~~ consultation services provider must notify the participant, the participant's representative,

626.20 and the commissioner 30 days prior to terminating services to the participant, and must
 626.21 assist the commissioner and lead agency in supporting the participant in transitioning to
 626.22 another CFSS agency-provider ~~or~~, FMS provider, or consultation services provider of the
 626.23 participant's choice.

626.24 (d) In the event the commissioner withholds payment from a CFSS agency-provider ~~or~~,
 626.25 FMS provider, or consultation services provider, or suspends or terminates a provider
 626.26 enrollment number of a CFSS agency-provider ~~or~~, FMS provider, or consultation services
 626.27 provider under this subdivision or section 256B.064, the commissioner may inform the
 626.28 Office of Ombudsman for Long-Term Care and the lead agencies for all participants with
 626.29 active service agreements with the agency-provider ~~or~~, FMS provider, or consultation
 626.30 services provider. At the commissioner's request, the lead agencies must contact participants
 626.31 to ensure that the participants are continuing to receive needed care, and that the participants
 626.32 have been given free choice of agency-provider ~~or~~, FMS provider, or consultation services
 626.33 provider if they transfer to another CFSS agency-provider ~~or~~, FMS provider, or consultation
 626.34 services provider. In addition, the commissioner or the commissioner's delegate may directly
 626.35 notify participants who receive care from the agency-provider ~~or~~, FMS provider, or
 627.1 consultation services provider that payments have been or will be withheld or that the
 627.2 provider's participation in medical assistance has been or will be suspended or terminated,
 627.3 if the commissioner determines that the notification is necessary to protect the welfare of
 627.4 the participants.

583.30 and the commissioner 30 days prior to terminating services to the participant, and must
 583.31 assist the commissioner and lead agency in supporting the participant in transitioning to
 583.32 another CFSS agency-provider ~~or~~, FMS provider, or consultation services provider of the
 583.33 participant's choice.

584.1 (d) In the event the commissioner withholds payment from a CFSS agency-provider ~~or~~,
 584.2 FMS provider, or consultation services provider, or suspends or terminates a provider
 584.3 enrollment number of a CFSS agency-provider ~~or~~, FMS provider, or consultation services
 584.4 provider under this subdivision or section 256B.064, the commissioner may inform the
 584.5 Office of Ombudsman for Long-Term Care and the lead agencies for all participants with
 584.6 active service agreements with the agency-provider ~~or~~, FMS provider, or consultation
 584.7 services provider. At the commissioner's request, the lead agencies must contact participants
 584.8 to ensure that the participants are continuing to receive needed care, and that the participants
 584.9 have been given free choice of agency-provider ~~or~~, FMS provider, or consultation services
 584.10 provider if they transfer to another CFSS agency-provider ~~or~~, FMS provider, or consultation
 584.11 services provider. In addition, the commissioner or the commissioner's delegate may directly
 584.12 notify participants who receive care from the agency-provider ~~or~~, FMS provider, or
 584.13 consultation services provider that payments have been or will be withheld or that the
 584.14 provider's participation in medical assistance has been or will be suspended or terminated,
 584.15 if the commissioner determines that the notification is necessary to protect the welfare of
 584.16 the participants.

584.17 Sec. 82. Minnesota Statutes 2020, section 256L.03, subdivision 1, is amended to read:

584.18 Subdivision 1. **Covered health services.** (a) "Covered health services" means the health
 584.19 services reimbursed under chapter 256B, with the exception of special education services,
 584.20 home care nursing services, adult dental care services other than services covered under
 584.21 section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation
 584.22 services, personal care assistance and case management services, community first services
 584.23 and supports under Minnesota Statutes, section 256B.85, behavioral health home services
 584.24 under section 256B.0757, housing stabilization services under section 256B.051, and nursing
 584.25 home or intermediate care facilities services.

584.26 (b) No public funds shall be used for coverage of abortion under MinnesotaCare except
 584.27 where the life of the female would be endangered or substantial and irreversible impairment
 584.28 of a major bodily function would result if the fetus were carried to term; or where the
 584.29 pregnancy is the result of rape or incest.

584.30 (c) Covered health services shall be expanded as provided in this section.

584.31 (d) For the purposes of covered health services under this section, "child" means an
 584.32 individual younger than 19 years of age.

585.1 Sec. 83. **REVISOR INSTRUCTION.**

585.2 (a) In Minnesota Statutes, sections 245A.191, paragraph (a); 245G.02, subdivision 3;
 585.3 246.18, subdivision 2; 246.23, subdivision 2; 246.64, subdivision 3; 254A.03, subdivision

585.4 3; 254A.19, subdivision 4; 254B.03, subdivision 2; 254B.04, subdivision 1; 254B.05,
585.5 subdivisions 1a and 4; 254B.051; 254B.06, subdivision 1; 254B.12, subdivisions 1 and 2;
585.6 254B.13, subdivisions 2a and 5; 254B.14, subdivision 5; 256L.03, subdivision 2; and 295.53,
585.7 subdivision 1, the revisor of statutes must change the term "consolidated chemical
585.8 dependency treatment fund" or similar terms to "behavioral health fund." The revisor may
585.9 make grammatical changes related to the term change.

585.10 (b) In Minnesota Statutes, sections 245C.03, subdivision 13, and 256B.051, the revisor
585.11 of statutes must change the term "housing support services" or similar terms to "housing
585.12 stabilization services." The revisor may make grammatical changes related to the term
585.13 change.

585.14 (c) In Minnesota Statutes, section 245C.03, subdivision 10, the revisor of statutes must
585.15 change the term "group residential housing" to "housing support." The revisor may make
585.16 grammatical changes related to the term change.

585.17 Sec. 84. **REPEALER.**

585.18 (a) Minnesota Statutes 2020, section 252.28, subdivisions 1 and 5, are repealed.

585.19 (b) Minnesota Statutes 2020, sections 252A.02, subdivisions 8 and 10; and 252A.21,
585.20 subdivision 3, are repealed.

585.21 **EFFECTIVE DATE.** Paragraph (a) is effective the day following final enactment.

585.22 Paragraph (b) is effective August 1, 2021.