ARTICLE 1

DISABILITY SERVICES

Section 1. Minnesota Statutes 2022, section 144G.45, subdivision 3, is amended to read:

Subd. 3. Local laws apply. Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county.

Sec. 2. Minnesota Statutes 2022, section 245A.11, subdivision 2, is amended to read:

Subd. 2. Permitted single-family residential use. (a) Residential programs with a licensed capacity of six or fewer persons shall be considered a permitted single-family residential use of property for the purposes of zoning and other land use regulations, except a residential program whose primary purpose is to treat juveniles who have violated criminal statutes relating to sex offenses or have been adjudicated delinquent on the basis of conduct in violation of criminal statutes relating to sex offenses shall not be considered a permitted use. This exception shall not apply to residential programs licensed before July 1, 1995. Programs otherwise allowed under this subdivision shall not be prohibited by operation of restrictive covenants or similar restrictions, regardless of when entered into, which cannot be met because of the nature of the licensed program, including provisions which require the home's occupants be related, and that the home must be occupied by the owner, or similar provisions.

(b) Unless otherwise provided in any town, municipal, or county zoning regulation, licensed residential services provided to more than four persons with developmental disabilities in a supervised living facility, including intermediate care facilities for persons with developmental disabilities, a facility with a licensed resident capacity of seven to eight persons and a facility with a licensed resident capacity of six or fewer persons shall be considered a permitted single-family residential use of property for the purpose of zoning and other land use regulations. A town, municipal, or county zoning authority may require a conditional use or special use permit to assure proper maintenance and operation of the residential program. Conditions imposed on the residential program must not be more restrictive than those imposed on other conditional uses or special uses of residential property in the same zones, unless the additional conditions are necessary to protect the health and safety of the persons being served by the program. This paragraph expires July 1, 2023.

(c) A residential program as defined in section 245D.02, subdivision 4a, with a licensed capacity of six or fewer persons that is actively serving residents for which it is licensed is exempt from rental licensing regulations imposed by any town, municipality, or county.
Sec. 3. Minnesota Statutes 2022, section 245D.071, subdivision 3, is amended to read:

in an incident as defined in section 245D.02, subdivision 11, clauses (4) to (7), suspension must be conducted annually at a minimum or within 30 days of a written request from the legal representative to determine the following based on information obtained from the assessments identified in paragraph (b), the person's identified needs in the support plan, (3) the person's ability to self-manage symptoms or behavior that may otherwise result jeopardy the health and welfare of the person or others.

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

(c) Before providing 45 days of service or within 60 calendar days of service initiation, whichever is shorter, the license holder must meet hold an initial planning meeting with the person, the person's legal representative, the case manager, other members of the support team or expanded support team, and other people as identified by the person or the person's legal representative to determine the following based on information obtained from the assessments identified in paragraph (b), the person's identified needs in the support plan, and the requirements in subdivision 4 and section 245D.07, subdivision 1a:

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

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

(3) the person's preferences for how services and supports are provided, including how the provider will support the person to have control of the person's schedule;
whether the current service setting is the most integrated setting available and
appropriate for the person;

(5) opportunities to develop and maintain essential and life-enriching skills, abilities,
strengths, interests, and preferences;

(6) opportunities for community access, participation, and inclusion in preferred
community activities;

(7) opportunities to develop and strengthen personal relationships with other persons of
the person's choice in the community;

(8) opportunities to seek competitive employment and work at competitively paying
jobs in the community; and

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

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

Sec. 4. Minnesota Statutes 2022, section 245D.071, subdivision 4, is amended to read:
Subd. 4. Service outcomes and supports. (a) Within ten working days of the initial
planning meeting, the license holder must develop a service plan that documents the
service outcomes and supports based on the assessments completed under subdivision 3
and the requirements in section 245D.07, subdivision 1a. The outcomes and supports must
be included in the support plan addendum.

(b) The license holder must document the supports and methods to be implemented to
support the person and accomplish outcomes related to acquiring, retaining, or improving
skills and physical, mental, and emotional health and well-being. The documentation must
include:

(i) any changes or modifications to the physical and social environments necessary when
the service supports are provided;

(ii) any equipment and materials required; and

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

(d) A discussion of how technology might be used to meet the person's desired outcomes
must be included in the initial planning meeting. The support plan or support plan
addendum must include a summary of this discussion. The summary must include a statement
regarding any decision that is made regarding the use of technology and a description of
any further research that needs to be completed before a decision regarding the use of
technology can be made. Nothing in this paragraph requires that the support plan include
the use of technology for the provision of services.
(iii) techniques that are consistent with the person's communication mode and learning style;

(2) the measurable and observable criteria for identifying when the desired outcome has been achieved and how data will be collected;

(3) the projected starting date for implementing the supports and methods and the date by which progress towards accomplishing the outcomes will be reviewed and evaluated;

and

(4) the names of the staff or position responsible for implementing the supports and methods.

(c) Within 20 working days of the 45-day initial planning meeting, the license holder must submit to and obtain dated signatures from the person or the person's legal representative and case manager to document completion and approval of the assessment and support plan addendum. If, within ten working days of the submission of the assessment or support plan addendum, the person or the person's legal representative or case manager has not signed and returned to the license holder the assessment and support plan addendum or has not proposed written modifications to the license holder's submission, the submission is deemed approved and the assessment and support plan addendum become effective and remain in effect until the legal representative or case manager submits a written request to revise the assessment or support plan addendum.

Sec. 5. Minnesota Statutes 2022, section 245D.081, subdivision 2, is amended to read:

Subd. 2. Coordination and evaluation of individual service delivery. (a) Delivery and evaluation of services provided by the license holder must be coordinated by a designated staff person. Except as provided in clause (3), the designated coordinator must provide supervision, support, and evaluation of activities that include:

(1) oversight of the license holder's responsibilities assigned in the person's support plan and the support plan addendum;

(2) taking the action necessary to facilitate the accomplishment of the outcomes according to the requirements in section 245D.07;

(3) instruction and assistance to direct support staff implementing the support plan and the service outcomes, including direct observation of service delivery sufficient to assess staff competency. The designated coordinator may delegate the direct observation and competency assessment of the service delivery activities of direct support staff to an individual whom the designated coordinator has previously deemed competent in those activities;

and

(4) evaluation of the effectiveness of service delivery, methodologies, and progress on the person's outcomes based on the measurable and observable criteria for identifying when the desired outcome has been achieved according to the requirements in section 245D.07.
(b) The license holder must ensure that the designated coordinator is competent to perform the required duties identified in paragraph (a) through education, training, and work experience relevant to the primary disability of persons served by the license holder and the individual persons for whom the designated coordinator is responsible. The designated coordinator must have the skills and ability necessary to develop effective plans and to design and use data systems to measure effectiveness of services and supports. The license holder must verify and document competence according to the requirements in section 245D.09, subdivision 3. The designated coordinator must minimally have:

1. A baccalaureate degree in a field related to human services and one year of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older;

2. An associate degree in a field related to human services and two years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older;

3. A diploma in a field related to human services from an accredited postsecondary institution and three years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older or

4. A minimum of 50 hours of education and training related to human services and

5. Four years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older under the supervision of a staff person who meets the qualifications identified in clauses (1) to (3).

Sec. 6. Minnesota Statutes 2022, section 245D.081, subdivision 3, is amended to read:

Subd. 3. Program management and oversight. (a) The license holder must designate a managerial staff person or persons to provide program management and oversight of the services provided by the license holder. The designated manager is responsible for the following:

1. Maintaining a current understanding of the licensing requirements sufficient to ensure compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph (e), and when applicable, as identified in section 256B.04, subdivision 21, paragraph (g);

2. Ensuring the duties of the designated coordinator are fulfilled according to the requirements in subdivision 2;

3. Ensuring the program implements corrective action identified as necessary by the program following review of incident and emergency reports according to the requirements in section 245D.11, subdivision 2, clause (7). An internal review of incident reports of

(b) The license holder must ensure that the designated coordinator is competent to perform the required duties identified in paragraph (a) through education, training, and work experience relevant to the primary disability of persons served by the license holder and the individual persons for whom the designated coordinator is responsible. The designated coordinator must have the skills and ability necessary to develop effective plans and to design and use data systems to measure effectiveness of services and supports. The license holder must verify and document competence according to the requirements in section 245D.09, subdivision 3. The designated coordinator must minimally have:

1. A baccalaureate degree in a field related to human services, education, or health and one year of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older; or

2. An associate degree in a field related to human services, education, or health and two years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older;

3. A diploma in a field related to human services, education, or health from an accredited postsecondary institution and three years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older or

4. A minimum of 50 hours of education and training related to human services and

5. Four years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older under the supervision of a staff person who meets the qualifications identified in clauses (1) to (3).
alleged or suspected maltreatment must be conducted according to the requirements in section 245A.65, subdivision 1, paragraph (b);

(4) evaluation of satisfaction of persons served by the program, the person's legal representative, if any, and the case manager, with the service delivery and progress toward accomplishing outcomes identified in sections 245D.07 and 245D.071, and ensuring and protecting each person's rights as identified in section 245D.04;

(5) ensuring staff competency requirements are met according to the requirements in section 245D.09, subdivision 3, and ensuring staff orientation and training is provided according to the requirements in section 245D.09, subdivisions 4, 4a, and 5;

(6) ensuring corrective action is taken when ordered by the commissioner and that the terms and conditions of the license and any variances are met; and

(7) evaluating the information identified in clauses (1) to (6) to develop, document, and implement ongoing program improvements.

(b) The designated manager must be competent to perform the duties as required and must minimally meet the education and training requirements identified in subdivision 2, paragraph (b), and have a minimum of three years of supervisory level experience in a program providing direct support services to persons with disabilities or persons age 65 and older.

Sec. 7. Minnesota Statutes 2022, section 245D.09, subdivision 3, is amended to read:

Subd. 3. Staff qualifications. (a) The license holder must ensure that staff providing direct support, or staff who have responsibilities related to supervising or managing the provision of direct support service, are competent as demonstrated through skills and knowledge training, experience, and education relevant to the primary disability of the person and to meet the person's needs and additional requirements as written in the support plan or support plan addendum, or when otherwise required by the case manager or the federal waiver plan. The license holder must verify and maintain evidence of staff competency, including documentation of:

(1) education and experience qualifications relevant to the job responsibilities assigned to the staff and to the primary disability of persons served by the program, including a valid degree and transcript, or a current license, registration, or certification, when a degree or licensure, registration, or certification is required by this chapter or in the support plan or support plan addendum;

(2) demonstrated competency in the orientation and training areas required under this chapter, and when applicable, completion of continuing education required to maintain professional licensure, registration, or certification requirements. Competency in these areas is determined by the license holder through knowledge testing or observed skill assessment conducted by the trainer or instructor or by an individual who has been previously deemed competent by the trainer or instructor in the area being assessed; and

(3) demonstrating knowledge and skill in the areas identified in clauses (1) and (2) by conducting an orientation and training assessment.

(b) The designated manager must be competent to perform the duties as required and must minimally meet the education and training requirements identified in subdivision 2, paragraph (b), and have a minimum of three years of supervisory level experience in a program providing direct support services to persons with disabilities or persons age 65 and older that provides care or education to vulnerable adults or children.

Sec. 7. Minnesota Statutes 2022, section 245D.09, subdivision 3, is amended to read:

Subd. 3. Staff qualifications. (a) The license holder must ensure that staff providing direct support, or staff who have responsibilities related to supervising or managing the provision of direct support service, are competent as demonstrated through skills and knowledge training, experience, and education relevant to the primary disability of the person and to meet the person's needs and additional requirements as written in the support plan or support plan addendum, or when otherwise required by the case manager or the federal waiver plan. The license holder must verify and maintain evidence of staff competency, including documentation of:

(1) education and experience qualifications relevant to the job responsibilities assigned to the staff and to the primary disability of persons served by the program, including a valid degree and transcript, or a current license, registration, or certification, when a degree or licensure, registration, or certification is required by this chapter or in the support plan or support plan addendum;

(2) demonstrated competency in the orientation and training areas required under this chapter, and when applicable, completion of continuing education required to maintain professional licensure, registration, or certification requirements. Competency in these areas is determined by the license holder through knowledge testing or observed skill assessment conducted by the trainer or instructor or by an individual who has been previously deemed competent by the trainer or instructor in the area being assessed; and

(3) demonstrating knowledge and skill in the areas identified in clauses (1) and (2) by conducting an orientation and training assessment.
Sec. 8. Minnesota Statutes 2022, section 245D.091, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

(3) be determined by a positive support professional to have the training and prerequisite skills required to provide positive practice strategies as well as behavior reduction approved and permitted intervention to the person who receives positive support; and
(g) Meeting the qualifications for a positive support professional under subdivision 2 shall substitute for meeting the qualifications listed in paragraph (b).

EFFECTIVE DATE. This section is effective July 1, 2024, or upon federal approval, whichever occurs first. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 9. Minnesota Statutes 2022, section 245D.091, subdivision 4, is amended to read:

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

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

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

(b) In addition, a behavior specialist must:

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective July 1, 2024, or upon federal approval, whichever occurs first. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained.
Subdivision 1. Policy and procedure requirements. A license holder providing either basic or intensive supports and services must establish, enforce, and maintain policies and procedures as required in this chapter, chapter 245A, and other applicable state and federal laws and regulations governing the provision of home and community-based services licensed according to this chapter. A license holder must use forms provided by the commissioner to report service suspensions and service terminations under subdivisions 3 and 3a.

**EFFECTIVE DATE.** This section is effective August 1, 2024.

Subd. 9. Employed persons with disabilities. (a) Medical assistance may be paid for a person who is employed and who:

(1) but for excess earnings or assets meets the definition of disabled under the Supplemental Security Income program; and

(2) pays a premium and other obligations under paragraph (e).

(b) For purposes of eligibility, there is a $65 earned income disregard. To be eligible for medical assistance under this subdivision, a person must have more than $65 of earned income, before receiving an unemployment insurance benefit under chapter 268 that the person began receiving while eligible under this subdivision, or be receiving family and medical leave benefits under chapter 268B that the person began receiving while eligible under this subdivision. Earned income must have Medicare, Social Security, and applicable state and federal taxes withheld. The person must document earned income tax withholding. Any spousal income shall be disregarded for purposes of eligibility and premium determinations.

(c) After the month of enrollment, a person enrolled in medical assistance under this subdivision who would otherwise be ineligible and be disenrolled due to one of the following circumstances may retain eligibility for up to four consecutive months after a month of job loss if the person:

(1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician, advanced practice registered nurse, or physician assistant; or

(2) loses employment for reasons not attributable to the enrollee, and is without receipt of earned income.

To receive a four-month extension of continued eligibility under this paragraph, enrollees must verify the medical condition or provide notification of job loss, continue to meet all other eligibility requirements, and continue to pay all calculated premium costs.

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Subdivision 1. Policy and procedure requirements. A license holder providing either basic or intensive supports and services must establish, enforce, and maintain policies and procedures as required in this chapter, chapter 245A, and other applicable state and federal laws and regulations governing the provision of home and community-based services licensed according to this chapter. A license holder must use forms provided by the commissioner to report service suspensions and service terminations under subdivisions 3 and 3a.

**EFFECTIVE DATE.** This section is effective August 1, 2024.
(d) All enrollees must pay a premium to be eligible for medical assistance under this
subdivision, except as provided under clause (5).

(1) An enrollee must pay the greater of a $35 premium or the premium calculated based
on the person’s gross earned and unearned income and the applicable family size using a
sliding fee scale established by the commissioner, which begins at one percent of income
at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for
those with incomes at or above 300 percent of the federal poverty guidelines.

(2) Annual adjustments in the premium schedule based upon changes in the federal
poverty guidelines shall be effective for premiums due in July of each year.

(3) All enrollees who receive unearned income must pay one-half of one percent of
unearned income in addition to the premium amount, except as provided under clause (5).

(4) Increases in benefits under title II of the Social Security Act shall not be counted as
income for purposes of this subdivision until July 1 of each year.

(5) Effective July 1, 2009, American Indians are exempt from paying premiums as
required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public
Law 111-5. For purposes of this clause, an American Indian is any person who meets the
definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(e) A person’s eligibility and premium shall be determined by the local county agency.

Premiums must be paid to the commissioner. All premiums are dedicated to the
commissioner.

(f) Any required premium shall be determined at application and redetermined at the
enrollee’s six-month 12-month income review or when a change in income or household
size is reported. Enrollees must report any change in income or household size within ten
30 days of when the change occurs. A decreased premium resulting from a reported change
in income or household size shall be effective the first day of the next available billing
month after the change is reported. Except for changes occurring from annual cost-of-living
increases, a change resulting in an increased premium shall not affect the premium amount
until the next six-month 12-month review.

(g) Premium payment is due upon notification from the commissioner of the premium
amount required. Premiums may be paid in installments at the discretion of the commissioner.

(b) Nonpayment of the premium shall result in denial or termination of medical assistance
unless the person demonstrates good cause for nonpayment. "Good cause" means an excuse
for the enrollee's failure to pay the required premium when due because the circumstances
were beyond the enrollee’s control or not reasonably foreseeable. The commissioner shall
determine whether good cause exists based on the weight of the supporting evidence
submitted by the enrollee to demonstrate good cause. Except when an installment agreement
is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must
pay any past due premiums as well as current premiums due prior to being reenrolled.
Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

(i) For enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner shall reimburse the enrollee for Medicare part B premiums under section 256B.0625, subdivision 15, paragraph (a).

(j) The commissioner is authorized to determine that a premium amount was calculated or billed in error, make corrections to financial records and billing systems, and refund premiums collected in error.

Sec. 12. Minnesota Statutes 2022, section 256B.0659, subdivision 17a, is amended to read:

Subd. 17a. Enhanced rate. (a) An enhanced rate of 107.5 percent of the rate paid for personal care assistance services shall be paid for services provided to persons who qualify for ten or more hours of personal care assistance services per day when provided by a personal care assistant who meets the requirements of subdivision 11, paragraph (d).

(b) A personal care assistance provider must use all additional revenue attributable to the rate enhancements under this subdivision for the wages and wage-related costs of the personal care assistants, including any corresponding increase in the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation premiums. The agency must not use the additional revenue attributable to any enhanced rate under this subdivision to pay for mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, contributions to employee retirement accounts, or any other employee benefits.

(c) Any change in the eligibility criteria for the enhanced rate for personal care assistance services as described in this subdivision and referenced in subdivision 11, paragraph (d), does not constitute a change in a term or condition for individual providers as defined in section 256B.0711, and is not subject to the state's obligation to meet and negotiate under chapter 179A.

EFFECTIVE DATE. This section is effective July 1, 2024.

Sec. 13. Minnesota Statutes 2023 Supplement, section 256B.0659, subdivision 24, is amended to read:

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

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

(2) comply with general medical assistance coverage requirements;
(3) demonstrate compliance with law and policies of the personal care assistance program to be determined by the commissioner;

(4) comply with background study requirements;

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

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

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

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

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

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

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

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

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

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

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

(16) document that the agency uses the additional revenue due to the enhanced rate under subdivision 17a for the wages and benefits and any corresponding increase in the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation premiums of the PCAs whose services meet the requirements under subdivision 11, paragraph (d), and

(17) ensure that a personal care assistant driving a recipient under subdivision 1, paragraph (i), has a valid driver's license and the vehicle used is registered and insured according to Minnesota law.

EFFECTIVE DATE. This section is effective July 1, 2024.
Sec. 10. Minnesota Statutes 2022, section 256B.0911, subdivision 24, is amended to read:

(a) Lead agencies must not implement additional requirements, in addition to those required by the commissioner, that could result in the delay of approval or implementation of technology.

(b) For services provided by the developmental disabilities waiver under section 256B.092, and the community access for disability inclusion, community alternative care, and brain injury waiver programs under section 256B.49, remote reassessments may be substituted for two consecutive reassessments if followed by an in-person reassessment.

(c) For services provided by alternative care under section 256B.0913, essential community supports under section 256B.0922, and the elderly waiver under chapter 256S, remote reassessments may be substituted for one reassessment if followed by an in-person reassessment.

(d) For personal care assistance provided under section 256B.0659 and community first services and supports provided under section 256B.85, remote reassessments may be substituted for two consecutive reassessments if followed by an in-person reassessment.

(EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval, whichever occurs later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.)

Sec. 11. Minnesota Statutes 2022, section 256B.092, is amended by adding a subdivision to read:

Subd. 3a. Authorization of technology services. (a) Lead agencies must not implement additional requirements, in addition to those required by the commissioner, that could result in the delay of approval or implementation of technology.
(b) For individuals receiving waiver services under this section, approval or denial of technology must occur within 30 business days of the receipt of the initial request. If denied, the lead agency must submit a notice of action form clearly stating the reason for the denial, including information describing why the technology is not appropriate to meet the individual's assessed need.

Sec. 16. Minnesota Statutes 2022, section 256B.49, is amended by adding a subdivision to read:

Subd. 16b. Authorization of technology services. (a) Lead agencies must not implement additional requirements, in addition to those required by the commissioner, that could result in the delay of approval or implementation of technology.

(b) For individuals receiving waiver services under this section, approval or denial of technology must occur within 30 business days of the receipt of the initial request. If denied, the lead agency must submit a notice of action form clearly stating the reason for the denial, including information describing why the technology is not appropriate to meet the individual's assessed need.

Sec. 17. Minnesota Statutes 2022, section 256B.4905, subdivision 12, is amended to read:

Subd. 12. Informed choice in and technology prioritization in implementation for disability waiver services. The commissioner of human services shall ensure that:

1. (1) disability waivers under sections 256B.092 and 256B.49 support the presumption that all adults who have disabilities and children who have disabilities may use assistive technology, remote supports, or both to enhance the adult's or child's independence and quality of life; and

2. (2) each individual accessing waiver services is offered, after an informed decision-making process and during a person-centered planning process, the opportunity to choose assistive technology, remote support, or both prior to the commissioner offering or reauthorizing services that utilize direct support staff to ensure equitable access.

Sec. 18. Minnesota Statutes 2023 Supplement, section 256B.4914, subdivision 4, is amended to read:

Subd. 4. Data collection for rate determination. (a) Rates for applicable home and community-based waivered services, including customized rates under subdivision 12, are set by the rates management system.

(b) Data and information in the rates management system must be used to calculate an individual's rate.

(c) Service providers, with information from the support plan and oversight by lead agencies, shall provide values and information needed to calculate an individual's rate in the rates management system. Lead agencies must use forms provided by the commissioner to collect this information. The determination of service levels must be part of a discussion to collect this information.
with members of the support team as defined in section 245D.02, subdivision 34. This discussion must occur prior to the final establishment of each individual's rate. The values and information include:

(1) shared staffing hours;
(2) individual staffing hours;
(3) direct registered nurse hours;
(4) direct licensed practical nurse hours;
(5) staffing ratios;
(6) information to document variable levels of service qualification for variable levels of reimbursement in each framework;
(7) shared or individualized arrangements for unit-based services, including the staffing ratio;
(8) number of trips and miles for transportation services; and
(9) service hours provided through monitoring technology.

(2) meeting the requirements for staffing under subdivision 2, paragraphs (h), (n), and (o); and meeting or exceeding the licensing standards for staffing required under section 245D.31.

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

Agencies must notify the individual and the lead agencies to correct it. Lead agencies must respond to these requests. When responding to the request, the lead agency must consider:

(1) meeting the health and welfare needs of the individual or individuals receiving services by service site, identified in their support plan under section 245D.02, subdivision 4b, and any addendum under section 245D.02, subdivision 4c; and
(2) meeting the requirements for staffing under subdivision 2, paragraph (o); and meeting or exceeding the licensing standards for staffing required under section 245D.09, subdivision 1; and
(3) meeting the staffing ratio requirements under subdivision 2, paragraph (o), and meeting or exceeding the licensing standards for staffing required under section 245D.31.

(4) direct licensed practical nurse hours;
(5) staffing ratios;
(6) information to document variable levels of service qualification for variable levels of reimbursement in each framework;
(7) shared or individualized arrangements for unit-based services, including the staffing ratio;
(8) number of trips and miles for transportation services; and
(9) service hours provided through monitoring technology.

(4) direct licensed practical nurse hours;
(5) staffing ratios;
(6) information to document variable levels of service qualification for variable levels of reimbursement in each framework;
(7) shared or individualized arrangements for unit-based services, including the staffing ratio;
(8) number of trips and miles for transportation services; and
(9) service hours provided through monitoring technology.

(5) staffing ratios;
(6) information to document variable levels of service qualification for variable levels of reimbursement in each framework;
(7) shared or individualized arrangements for unit-based services, including the staffing ratio;
(8) number of trips and miles for transportation services; and
(9) service hours provided through monitoring technology.

(6) information to document variable levels of service qualification for variable levels of reimbursement in each framework;
(7) shared or individualized arrangements for unit-based services, including the staffing ratio;
(8) number of trips and miles for transportation services; and
(9) service hours provided through monitoring technology.

(7) shared or individualized arrangements for unit-based services, including the staffing ratio;
(8) number of trips and miles for transportation services; and
(9) service hours provided through monitoring technology.

(8) number of trips and miles for transportation services; and
(9) service hours provided through monitoring technology.

(9) service hours provided through monitoring technology.

(9) service hours provided through monitoring technology.
This section is effective January 1, 2025.

Subd. 2. Definitions. (a) For the purposes of this section and section 256B.851, the terms defined in this subdivision have the meanings given.

(b) "Activities of daily living" or "ADLs" means:

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

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

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

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

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

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

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

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

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

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

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

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

- toileting, including assistance with bowel or bladder elimination and care, transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and adjusting clothing.
- bathing, including assistance with basic personal hygiene and skin care.
- eating, including assistance with hand washing and applying orthotics required for eating, transferr, or feeding.
- transfers, including assistance with transferring the participant from one seating or reclining area to another.
- mobility, including assistance with ambulation and use of a wheelchair. Mobility does not include providing transportation for a participant.
- positioning, including assistance with positioning or turning a participant for necessary care and comfort; and
- toileting, including assistance with bowel or bladder elimination and care, transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and adjusting clothing.

This section is effective January 1, 2025.
16.10 (1) tube feedings requiring:
16.11 (i) a gastrojejunostomy tube; or
16.12 (ii) continuous tube feeding lasting longer than 12 hours per day;
16.13 (2) wounds described as:
16.14 (i) stage III or stage IV;
16.15 (ii) multiple wounds;
16.16 (iii) requiring sterile or clean dressing changes or a wound vac; or
16.17 (iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized care;
16.18 (3) parenteral therapy described as:
16.19 (i) IV therapy more than two times per week lasting longer than four hours for each treatment; or
16.20 (ii) total parenteral nutrition (TPN) daily;
16.21 (4) respiratory interventions, including:
16.22 (i) oxygen required more than eight hours per day;
16.23 (ii) respiratory vest more than one time per day;
16.24 (iii) bronchial drainage treatments more than two times per day;
16.25 (iv) sterile or clean suctioning more than six times per day;
16.26 (v) dependence on another to apply respiratory ventilation augmentation devices such as BIPAP and CPAP; and
16.27 (vi) ventilator dependence under section 256B.0651;
16.28 (v) dependence on another to apply respiratory ventilation augmentation devices such as BIPAP and CPAP; and
16.29 (i) sterile catheter changes more than one time per month;
16.30 (ii) clean intermittent catheterization, and including self-catheterization more than six times per day; or
16.31 (iii) bladder irrigations;
16.32 (6) bowel program more than two times per week requiring more than 30 minutes to perform each time;
16.33 (7) neurological intervention, including:
(i) seizures more than two times per week and requiring significant physical assistance to maintain safety; or

(ii) swallowing disorders diagnosed by a physician, advanced practice registered nurse, or physician's assistant and requiring specialized assistance from another on a daily basis; and

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

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

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

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

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

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

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

(m) "Financial management services provider" or "FMS provider" means a qualified organization required for participants using the budget model under subdivision 13 that is an enrolled provider with the department to provide vendor fiscal/employer agent financial management services (FMS).
"Health-related procedures and tasks" means procedures and tasks related to the specific assessed health needs of a participant that can be taught or assigned by a state-licensed health care or mental health professional and performed by a support worker.

(o) "Instrumental activities of daily living" means activities related to living independently in the community, including but not limited to: meal planning, preparation, and cooking; shopping for food, clothing, or other essential items; laundry; housecleaning; assistance with medications; managing finances; communicating needs and preferences during activities; arranging supports; and assistance with traveling around and participating in the community, including traveling to medical appointments. For purposes of this paragraph, traveling includes driving and accompanying the recipient in the recipient's chosen mode of transportation and according to the individual CFSS service delivery plan.

(p) "Lead agency" has the meaning given in section 256B.0911, subdivision 10.

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

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

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

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

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

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

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

(v) "Participant's representative" means a parent, family member, advocate, or other adult authorized by the participant or participant's legal representative, if any, to serve as a representative in connection with the provision of CFSS. If the participant is unable to assist in the selection of a participant's representative, the legal representative shall appoint one.
(v) "Person-centered planning process" means a process that is directed by the participant to plan for CFSS services and supports.

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

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

(y) "Support worker" means a qualified and trained employee of the agency-provider as required by subdivision 1b or of the participant employer under the budget model as required by subdivision 14 who has direct contact with the participant and provides services as specified within the participant's CFSS service delivery plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) The CFSS service delivery plan must describe the units or dollar amount available to the participant. The total units of agency-provider services or the service budget amount

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25.25  (e) In assisting with the development or modification of the CFSS service delivery plan
during the authorization time period, the consultation services provider shall:
25.26  (1) consult with the FMS provider on the spending budget when applicable; and
25.27  (2) consult with the participant or participant's representative, agency-provider, and case
25.28  manager or care coordinator.

The person-centered planning process
is determined according to subdivision 8, unless a change in condition is assessed and
authorized by the certified assessor and documented in the support plan and CFSS service delivery plan.

21.26  (e) In assisting with the development or modification of the CFSS service delivery plan
during the authorization time period, the consultation services provider shall:
21.27  (1) consult with the FMS provider on the spending budget when applicable; and
21.28  (2) consult with the participant or participant's representative, agency-provider, and case
21.29  manager or care coordinator.

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

Sec. 17. Minnesota Statutes 2022, section 256B.85, subdivision 6a, is amended to read:

21.26  Subd. 6a. Person-centered planning process. The person-centered planning process
21.27  must:
21.28  (1) include people chosen by the participant;
21.29  (2) provide necessary information and support to ensure that the participant directs the
21.30  process to the maximum extent possible, and is enabled to make informed choices and
decisions;
21.31  (3) be timely and occur at times and locations convenient to the participant;
21.32  (4) reflect cultural considerations of the participant;
21.33  (5) include within the process strategies for solving conflict or disagreement, including
21.34  clear conflict-of-interest guidelines as identified in Code of Federal Regulations, title 42,
section 441.500,441.540,for all planning;
21.35  (6) provide the participant choices of the services and supports the participant receives
and the staff providing those services and supports;
21.36  (7) include a method for the participant to request updates to the plan; and
21.37  (8) record the alternative home and community-based settings that were considered by
the participant.
Sec. 22. Minnesota Statutes 2022, section 256B.85, subdivision 7a, is amended to read:

Subd. 7a. Enhanced rate. (a) An enhanced rate of 107.5 percent of the rate paid for CFSS must be paid for services provided to persons who qualify for ten or more hours of CFSS per day when provided by a support worker who meets the requirements of subdivision 16, paragraph (e).

(b) An agency provider must use all additional revenue attributable to the rate enhancements under this subdivision for the wages and wage-related costs of the support workers, including any corresponding increase in the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation premiums.

The agency provider must not use the additional revenue attributable to any enhanced rate under this subdivision to pay for mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, contributions to employee retirement accounts, or any other employee benefits.

(c) Any change in the eligibility criteria for the enhanced rate for CFSS as described in this subdivision and referenced in subdivision 16, paragraph (e), does not constitute a change in a term or condition for individual providers as defined in section 256B.0711, and is not subject to the state's obligation to meet and negotiate under chapter 179A.

EFFECTIVE DATE. This section is effective July 1, 2024.

Sec. 23. Minnesota Statutes 2022, section 256B.85, subdivision 11, is amended to read:

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

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

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

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

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

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

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

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

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

(h) The agency provider is responsible for ensuring that any worker driving a participant under subdivision 2, paragraph (o), has a valid driver's license and the vehicle used is registered and insured according to Minnesota law.

Sec. 24. Subd. 13a. Financial management services. (a) Services provided by an FMS provider include but are not limited to: filing and payment of federal and state payroll taxes and premiums on behalf of the participant, initiating and complying with background study requirements under chapter 245C and maintaining documentation of background study requests and results; billing for approved CFSS services with authorized funds; monitoring expenditures; accounting for and disbursing CFSS funds; providing assistance in obtaining filing for liability, workers' compensation, family and medical benefit insurance, and unemployment coverage; and providing participant instruction and technical assistance to the participant in fulfilling employer-related requirements in accordance with section 3504 of the Internal Revenue Code and related regulations and interpretations, including Code of Federal Regulations, title 26, section 31.3504-1.

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

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

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

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

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

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

(e) The FMS provider shall:

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

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

(3) be knowledgeable of state and federal employment regulations, including those under
the Fair Labor Standards Act of 1938, and comply with the requirements under chapter
268B and section 3504 of the Internal Revenue Code and related regulations and
interpretations, including Code of Federal Regulations, title 26, section 31.3504-1, regarding
agency employer tax liability for vendor fiscal/employer agent, and any requirements
necessary to process employer and employee deductions, provide appropriate and timely
submission of employer tax liabilities, and maintain documentation to support medical
assistance claims;

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

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

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

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

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

(e) The FMS provider shall:

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

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

(3) be knowledgeable of state and federal employment regulations, including those under
the Fair Labor Standards Act of 1938, and comply with the requirements under chapter
268B and section 3504 of the Internal Revenue Code and related regulations and
interpretations, including Code of Federal Regulations, title 26, section 31.3504-1, regarding
agency employer tax liability for vendor fiscal/employer agent, and any requirements
necessary to process employer and employee deductions, provide appropriate and timely
submission of employer tax liabilities, and maintain documentation to support medical
assistance claims;

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

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

(6) maintain documentation of receipts, invoices, and bills to track all services and
supports expenditures for any goods purchased and maintain time records of support workers.
The documentation and time records must be maintained for a minimum of five years from
the claim date and be available for audit or review upon request by the commissioner. Claims
submitted by the FMS provider to the commissioner for payment must correspond with
services, amounts, and time periods as authorized in the participant's service budget and
service plan and must contain specific identifying information as determined by the
commissioner; and
(7) provide written notice to the participant or the participant's representative at least 30 calendar days before a proposed service termination becomes effective, except in cases where:

(i) the participant engages in conduct that significantly alters the terms of the CFSS service delivery plan with the FMS;

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

or

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

(f) The commissioner shall:

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

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

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

Sec. 20. Minnesota Statutes 2022, section 256B.85, subdivision 17, is amended to read:

Subd. 17. Consultation services duties. Consultation services is a required service that includes:

(1) entering into a written agreement with the participant, participant's representative, or legal representative that includes but is not limited to the details of services, service delivery methods, dates of services, and contact information;

(2) providing an initial and annual orientation to CFSS information and policies, including selecting a service model;

(3) assisting with accessing FMS providers or agency-providers;

(4) providing assistance with the development, implementation, management, documentation, and evaluation of the person-centered CFSS service delivery plan;

(5) approving the CFSS service delivery plan for a participant without a case manager or care coordinator who is responsible for authorizing services;

(6) maintaining documentation of the approved CFSS service delivery plan;
Subd. **18b.** Work training and development services; remote visits. (a) Except as provided in paragraph (b), the worker training and development services specified in subdivision 18a, paragraph (c), clauses (3) and (4), may be provided to recipients with chronic health conditions or severely compromised immune systems via two-way interactive audio and visual telecommunications if, at the recipient's request, the recipient's primary health care provider:

(1) determines that remote worker training and development services are appropriate; and

(2) documents the determination under clause (1) in a statement of need or other document that is subsequently included in the recipient's CFSS service delivery plan.

(b) Worker training and development services; remote visits. (1) determines that remote worker training and development services are appropriate; and

(2) documents the determination under clause (1) in a statement of need or other document that is subsequently included in the recipient's CFSS service delivery plan.
(b) The worker training and development services specified in subdivision 18a, paragraph (c), clause (3), provided at the start of services or the start of employment of a new support worker must not be conducted via two-way interactive audio and visual telecommunications.

(g) A recipient may request to return to in-person worker training and development services at any time.

**EFFECTIVE DATE.** This section is effective July 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 27. Minnesota Statutes 2022, section 256B.85, subdivision 20, is amended to read:

Subd. 20. **Participant protections.** (a) All CFSS participants have the protections identified in this subdivision.

(b) Participants or participant's representatives must be provided with adequate information, counseling, training, and assistance, as needed, to ensure that the participant is able to choose and manage services, models, and budgets. This information must be provided by the consultation services provider at the time of the initial or annual orientation to CFSS, at the time of reassessment, or when requested by the participant or participant's representative. This information must explain:

1. person-centered planning;
2. the range and scope of participant choices, including the differences between the agency-provider model and the budget model, available CFSS providers, and other services available in the community to meet the participant's needs;
3. the process for changing plans, services, and budgets;
4. identifying and assessing appropriate services; and
5. risks to and responsibilities of the participant under the budget model.

(c) The consultation services provider must ensure that the participant chooses freely between the agency-provider model and the budget model and among available agency-providers that the participant may change agency-providers after services have begun.

(d) A participant who appeals a reduction in previously authorized CFSS services may continue previously authorized services pending an appeal in accordance with section 256.045.
If the units of service or budget allocation for CFSS are reduced, denied, or terminated, the commissioner must provide notice of the reasons for the reduction in the participant's notice of denial, termination, or reduction.

If all or part of a CFSS service delivery plan is denied approval by the consultation services provider lead agency, the consultation services provider lead agency must provide a notice that describes the basis of the denial.

Sec. 28. Laws 2021, First Special Session chapter 7, article 13, section 75, is amended to read:

Subd. 1. Stakeholder consultation; generally. (a) The commissioner of human services must consult with and seek input and assistance from stakeholders concerning potential adjustments to the streamlined service menu from waiver reimagine phase I and to the existing rate exemption criteria and process.

(b) The commissioner of human services must consult with, seek input and assistance from, and collaborate with stakeholders concerning the development and implementation of waiver reimagine phase II; including criteria and a process for individualized budget exemptions; and how waiver reimagine phase II can support and expand informed choice and informed decision making; including integrated employment, independent living, and self-direction; consistent with Minnesota Statutes, section 256B.4905.

(c) The commissioner of human services must consult with, seek input and assistance from, and collaborate with stakeholders concerning the implementation and revisions of the MnCHOICES 2.0 assessment tool.

Subd. 2. Public stakeholder engagement. The commissioner must offer a public method to regularly receive input and concerns from people with disabilities and their families about waiver reimagine phase II. The commissioner shall provide regular quarterly public updates on policy development and on how recent stakeholder input was used throughout the process being incorporated into the current development and implementation of waiver reimagine phase II.

Subd. 3. Waiver Reimagine Advisory Committee. (a) The commissioner must convene, at regular intervals throughout the development and implementation of waiver reimagine phase II, a Waiver Reimagine Advisory Committee that consists of a group of diverse, representative stakeholders. The commissioner must solicit and endeavor to include racially, ethnically, and geographically diverse membership from each of the following groups:

(1) people with disabilities who use waiver services;
(2) family members of people who use waiver services;
(3) disability and behavioral health advocates;
(4) lead agency representatives; and

(5) waiver service providers.

(b) The assistant commissioner of aging and disability services must attend and participate in meetings of the Waiver Reimagine Advisory Committee.

(c) The Waiver Reimagine Advisory Committee must have the opportunity to assist in the collaborative development and provide feedback on proposed plans for waiver reimagine components, including an individual budget methodology, criteria and a process for individualized budget exemptions, the consolidation of the four current home and community-based waiver service programs into two-waiver programs; the role of assessments and the MnCHOICES 2.0 assessment tool in determining service needs and individual budgets; and other aspects of waiver reimagine phase II.

(d) The Waiver Reimagine Advisory Committee must have an opportunity to assist in the development of and provide feedback on proposed adjustments and modifications to the streamlined menu of services and the existing rate exception criteria and process.

Subd. 4. Required report. Prior to seeking federal approval for any aspect of waiver reimagine phase II and in consultation with the Waiver Reimagine Advisory Committee, the commissioner must submit to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services a report on plans for waiver reimagine phase II. The report must also include any plans to adjust or modify the streamlined menu of services, the existing rate exception criteria or process, the proposed individual budget ranges, and the role of MnCHOICES 2.0 assessment tool in determining service needs and individual budget ranges.

Subd. 5. Transition process. (a) Prior to implementation of waiver reimagine phase II, the commissioner must establish a process to assist people who use waiver services and lead agencies transition to a two-waiver system with an individual budget methodology.

(b) The commissioner must ensure that the new waiver service menu and individual budgets allow people to live in their own home, family home, or any home and community-based setting of their choice. The commissioner must ensure that available resources and subject to state and federal regulations and law, waiver reimagine does not result in unintended service disruptions.

Subd. 6. Online support planning tool. The commissioner must develop an online support planning and tracking tool for people using disability waiver services that allows access to the total budget available to the person, the services for which they are eligible, and the services they have chosen and used. The commissioner must explore operability options that would facilitate real-time tracking of a person's remaining available budget throughout the service year. The online support planning tool must provide information in an accessible format to support the person's informed choice. The commissioner must seek input from people with disabilities about the online support planning tool prior to its implementation.
Subd. 7. Curriculum and training. The commissioner must develop and implement a curriculum and training plan to ensure all lead agency assessors and case managers have the knowledge and skills necessary to comply with informed decision making for people who used home and community-based disability waivers. Training and competency evaluations must be completed annually by all staff responsible for case management as described in Minnesota Statutes, sections 256B.092, subdivision 1a, paragraph (f), and 256B.49, subdivision 13, paragraph (e).

Sec. 29. COMMUNITY ACCESS FOR DISABILITY INCLUSION WAIVER CUSTOMIZED LIVING SERVICES PROVIDERS LOCATED IN HENNEPIN COUNTY.

The community access for disability inclusion (CADI) waiver customized living and 24-hour customized living size and age limitation does not apply to two housing settings located in the city of Minneapolis that are financed by low-income housing tax credits created in calendar years 2005 and 2011 and in which 24-hour customized living services are provided to residents enrolled in the CADI waiver by Clare Housing.