

586.1

**ARTICLE 15**

586.2

**COMMUNITY SUPPORTS POLICY**

520.10

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520.11

**COMMUNITY SUPPORTS POLICY**

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

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

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

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

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

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

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

520.28 (6) provide for case management services to each child with severe emotional disturbance  
520.29 according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881, subdivisions  
520.30 1, 3, and 5;

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

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

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

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

521.12 (11) assure that culturally competent mental health consultants are used as necessary to  
521.13 assist the county board in assessing and providing appropriate treatment for children of  
521.14 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~~ 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 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 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 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~~ support stabilization services are established to provide  
539.30 housing ~~support~~ 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;

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551.29 as BiPAP and CPAP; and

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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, 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, 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.